

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

\* \* \*

J.B.D.L. CORP. d/b/a : CIVIL ACTION

BECKETT APOTHECARY, et al. :

:

vs. :

:

WYETH-AYERST LABORATORIES, :

INC., et al. : NO. C-1-01-704

\* \* \*

MAY 18, 2004

\* \* \*

Videotape deposition of DAVID J.

GIBSON, M.D., taken pursuant to notice, was held at the law offices of REED SMITH LLP, 2500 One Liberty Place, 1650 Market Street, Philadelphia, Pennsylvania 19103-7301, beginning at 10:19 a.m., before McKinley Wise, a Registered Professional Reporter and an approved Reporter of the United States District Court.

\* \* \*

ESQUIRE DEPOSITION SERVICES

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## I N D E X

Testimony of DAVID J. GIBSON, M.D.

By Mr. Dobie

6

\* \* \*

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\* \* \*

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1 \* \* \*

2 (Whereupon, Gibson Exhibit 1 was

3 marked for identification.)

4 \* \* \*

5 THE VIDEOGRAPHER: Good morning.

6 Here begins Videotape No. 1 in the

7 deposition of David J. Gibson in the matter

8 of J.B.D.L. versus Wyeth in the United

9 States District Court, Southern District of

10 Ohio.

11 Today's date is May 18th, 2004, and

12 the time is 10:19 a.m. This deposition is

13 being taken at One Liberty Place in the law

14 offices of Reed Smith. The videographer is

15 Michael Panichelli here on behalf of Esquire

16 Deposition Services, located at 1880 JFK

17 Boulevard, Philadelphia, Pennsylvania

18 19103.

19 Would counsel and all present please

20 identify yourselves and state whom you

21 represent.

22 MR. COHEN: Jay Cohen for direct

23 purchaser plaintiffs.

24 MR. EINHORN: Gordon Einhorn for

1 A. Sacramento, California.

2 Q. And what's your address there?

3 A. 4830 Oak Vista Drive, Carmichael,

4 California.

5 Q. And how long have you lived in

6 Sacramento?

7 A. About seven years.

8 Q. Sir, I want to ask you some

9 questions about the expert report that you've

10 prepared in connection with this case, and we've

11 gone ahead and marked it as Gibson Exhibit 1.

12 A. Thank you.

13 Q. Take a moment and look at that. Is

14 that the expert report that you did, in fact,

15 prepare in this case, sir?

16 A. It appears to be.

17 Q. And before we get into the substance

18 of the report, let me just go over some ground

19 rules for the deposition here today.

20 First, if you would be careful to

21 let me finish my question before you begin to

22 respond, even though you probably know where I'm

23 going with my question or you think you may know.

24 If we do that, it will be much easier for the

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1 Rite Aid and CVS.

2 MR. DOBIE: Gordon Dobie for the

3 defendant Wyeth.

4 MS. WARD: Brooke Ward, also on

5 behalf of the defendant Wyeth.

6 THE VIDEOGRAPHER: The court

7 reporter is Mac Wise, and he will now swear

8 in the witness.

9 \* \* \*

10 DAVID J. GIBSON, M.D., after having

11 been first duly sworn, was examined and

12 testified as follows:

13 \* \* \*

14 THE COURT REPORTER: Any statements

15 for the record, counsel?

16 Hearing none, your witness, sir.

17 \* \* \*

18 EXAMINATION

19 \* \* \*

20 BY MR. DOBIE:

21 Q. Sir, would you state your name for

22 the record?

23 A. David Gibson.

24 Q. Mr. Gibson, where do you reside?

1 court reporter to get it down and we'll have a

2 much clearer record. Fair enough?

3 A. I reread our prior meeting on the

4 way out and I saw I stepped on your lines often,

5 so I'll try to do better today.

6 Q. Okay. Second, if you can make sure

7 you respond verbally to the questions, because

8 again a nod of the head, an uh-huh just doesn't

9 work that well on paper.

10 A. I understand.

11 Q. Okay. And finally if any of my

12 questions are unclear, if you let me know, and

13 I'll try to rephrase the question. Fair enough?

14 A. Fair enough.

15 Q. Before we get into the substance of

16 the report, I want to talk with you a little bit

17 more about your background, what you've been doing

18 since the deposition that you gave in connection

19 with the case Duramed versus -- versus Wyeth.

20 MR. DOBIE: And Jay, just as kind of

21 a preliminary matter, with most of the

22 depositions in the case or all the

23 depositions, I think we've taken the

24 position that depositions and documents from

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1 the Duramed case can also be used in the --  
 2 in the J.B.D.L. and the other cases.  
 3 Is that fair enough with this  
 4 witness? Because he does have a hundred-  
 5 page report and I'm trying -- going to try  
 6 to avoid going line -- line by line and  
 7 covering things that I did last time unless  
 8 I have to clarify a point or something like  
 9 that.  
 10 MR. COHEN: Sure. That would be  
 11 very much appreciated.  
 12 MR. DOBIE: Okay.  
 13 BY MR. DOBIE:  
 14 Q. Mr. Gibson, since your -- your last  
 15 deposition, looking at your background, I notice  
 16 you've undertaken some additional jobs, and one of  
 17 them is mentioned on Page 6 of your report. Up at  
 18 the top on Page 6 of your report, you state, "I  
 19 have also started a second company, the Fraud  
 20 Prevention Institute, that specializes in fraud  
 21 prevention within the health care industry. FPI  
 22 is made up of former Medi-Cal and FBI  
 23 investigators who have been working on  
 24 investigating and prosecuting fraudulent activity

1 little confused. Mr. Cates doesn't work for the  
 2 Fraud Prevention Institute, does he?  
 3 A. No one works for the Fraud  
 4 Prevention Institute at the present time. We have  
 5 no employees. We have a -- it's a non -- not-for-  
 6 profit company and each of us is either working on  
 7 a nonpaid basis or as a consultant as we bring  
 8 this company up from the start.  
 9 Q. And is Mr. Cates a -- it's a  
 10 nonprofit. Are there -- do you have members,  
 11 shareholders?  
 12 A. It's a business association is the  
 13 rough classification for this. We have -- we have  
 14 a not-for-profit shell in the state of California.  
 15 We do not -- we have not yet cleared the hurdles  
 16 with IRS and the franchise board.  
 17 \* \* \*  
 18 (Whereupon, Gibson Exhibit 2 was  
 19 marked for identification.)  
 20 \* \* \*  
 21 BY MR. DOBIE:  
 22 Q. Okay. let me show you what I've  
 23 marked as Exhibit 2. Sir, I'm handing you what we  
 24 marked as Exhibit 2. Exhibit 2 is a document that

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1 within health care for many years."  
 2 So that's an -- that's an additional  
 3 responsibility since your last deposition?  
 4 A. Correct.  
 5 Q. And your position with the Fraud  
 6 Prevention Institute is chief executive officer?  
 7 A. Correct.  
 8 Q. And who are these FBI investigators  
 9 and Medi-Cal investigators who are working for  
 10 FPI?  
 11 A. The two principals would be a fellow  
 12 by the name of Alan Cates, who is -- was appointed  
 13 by the governor, our former governor, Davis, to  
 14 head an investigative unit for the Department of  
 15 Health Services to -- to find and help control  
 16 fraud within the Medi-Cal program. And the second  
 17 person is Ed O'Donnell, O-D-o-n-n-e-l-l, who was a  
 18 special agent for -- in the FBI. He was awarded  
 19 the -- he was awarded the outstanding agent of the  
 20 year -- I may not have the exact award, but it was  
 21 awarded by the FBI director to him as being the  
 22 outstanding special agent on fraud investigations  
 23 a couple of years ago.  
 24 Q. Now, here's where I'm -- I was a

1 we pulled off the Web on May 15th of 2004. This  
 2 discuss an entity that's called the Medi-Cal Fraud  
 3 Prevention Bureau and it mentions that Governor  
 4 Davis had -- had appointed Alan Cates, who you  
 5 mentioned, to be the director of the Medi-Cal  
 6 Fraud Prevention Bureau. Do you see that?  
 7 A. I do.  
 8 Q. Okay. And it's the Medi-Cal Fraud  
 9 Prevention Bureau, is it not, sir, that's in the  
 10 business of investigating Medi-Cal fraud?  
 11 A. It is.  
 12 Q. All right. And the Medi-Cal Fraud  
 13 Prevention Bureau is the group that has the FBI  
 14 agents and others that are out investigating  
 15 Medi-Cal fraud; correct?  
 16 A. It has in the past. That's correct.  
 17 Q. All right. And -- and continues to  
 18 do so even today, doesn't it, sir?  
 19 A. It does.  
 20 Q. All right. And, for example, when  
 21 we talk about Medi-Cal fraud, some of the things  
 22 that -- that have been investigated recently, if  
 23 you're familiar with it, is -- include physician  
 24 and pharmacist fraud in California. Are you

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1 familiar with that?  
 2 A. Uh-huh.  
 3 Q. And various -- I guess various  
 4 prosecutions of physicians and people known as  
 5 runners that are submitting or assisting in  
 6 submission of fraudulent claims to Medi-Cal for  
 7 payment?  
 8 A. Correct.  
 9 Q. Is that correct? And the group that  
 10 you're involved in, FPI, sir --  
 11 A. Yes.  
 12 Q. -- that's actually something that  
 13 was started four years ago; correct?  
 14 A. No. We got our -- we -- we  
 15 incorporated last year, end of last year.  
 16 Q. Okay. You don't -- you don't work  
 17 for the Medi-Cal Fraud Prevention Bureau, do you?  
 18 A. No.  
 19 Q. You don't have a contract with them?  
 20 A. No, we -- I do not.  
 21 Q. And -- and your group is not  
 22 actually going out and investigating or  
 23 prosecuting Medi-Cal fraud, is it, sir?  
 24 MR. COHEN: Object -- object to the

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1 form as in what you referred to as "your  
 2 group."  
 3 BY MR. DOBIE:  
 4 Q. The FPI?  
 5 A. I'll try to be brief. This could be  
 6 a long discussion. But Fraud Prevention Institute  
 7 is -- takes the experience from the Fraud  
 8 Prevention Bureau and moves it into a different  
 9 sphere. The Fraud Prevention Bureau was involved  
 10 in prosecution of -- and felonies. The Fraud  
 11 Prevention Institute deals in the arena of  
 12 contract law, and the way the Fraud Prevention  
 13 Institute works is it is funded by membership in a  
 14 network of health care providers who contractually  
 15 agree to not engage in fraudulent activities, and  
 16 we monitor those activities.  
 17 Q. How many members do you have right  
 18 now, sir?  
 19 A. At present, we have about 70. We've  
 20 started with an organization in Los Angeles called  
 21 UPNI, or United Pharmacist Network, Inc. And  
 22 we're working with them to position them as a  
 23 recognized nonfraudulent network in an area of  
 24 California that has been a hot spot in the past

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1 for fraudulent activity.  
 2 Q. The membership that you're talking  
 3 about, the 70 members, does that include -- you  
 4 said the United Pharmacist Network. Who else?  
 5 A. That's it.  
 6 Q. That's it?  
 7 A. That's our first contract.  
 8 Q. All right.  
 9 MR. COHEN: Just for clarification,  
 10 I think he said 70. Did you say seven  
 11 members?  
 12 THE WITNESS: 70.  
 13 MR. COHEN: I'm sorry. I misheard.  
 14 THE WITNESS: And these are mostly  
 15 independent pharmacies.  
 16 MR. COHEN: Okay.  
 17 THE WITNESS: Community-based.  
 18 BY MR. DOBIE:  
 19 Q. But those 70 pharmacies are all  
 20 members of this United Pharmacist Network?  
 21 A. Correct.  
 22 Q. So your contract is with United  
 23 Pharmacist Network?  
 24 A. That's correct.

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1 Q. All right. You don't have a  
 2 contract with the Medi-Cal Fraud Prevention  
 3 Bureau?  
 4 A. No, we do not. We would like to  
 5 have a contract with the Department of Health  
 6 Services, but we do not as yet have that.  
 7 \* \* \*  
 8 (Whereupon, Gibson Exhibit 3 was  
 9 marked for identification.)  
 10 \* \* \*  
 11 BY MR. DOBIE:  
 12 Q. All right. Let me show you what's  
 13 been marked as Exhibit 3. Have you ever seen this  
 14 document before, sir?  
 15 A. No, I have not.  
 16 Q. This is -- I'll represent to you for  
 17 the record this is a document that again we pulled  
 18 off the Web relating to the United Pharmacist  
 19 Network that you were just referring to and it  
 20 also discusses this group FPI.  
 21 Let me ask you to turn -- the pages  
 22 aren't numbered -- to the fourth page. At the  
 23 bottom, it says "The Fraud Prevention Institute."  
 24 Do you see that?

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1 A. I do.

2 Q. And it turns over to the next page.

3 And going to the third paragraph, it talks about

4 "A recent four-year pilot of the FPI approach by

5 the Medi-Cal Fraud Prevention Bureau involving

6 over 6,000 providers eradicated over \$300 million

7 in fraud with undue disruption to the normal" --

8 "without undue disruption to the normal operations

9 of the vast majority of honest providers." Do you

10 see this?

11 A. I do, yes.

12 Q. Okay. Now, you mentioned that this

13 FPI group was just created in 2003. Are you

14 familiar with any four-year pilot that began all

15 the way in I guess the year 2000 by FPI?

16 A. It doesn't say that. What it says

17 is that the recent four-year pilot of the FPI

18 approach and the methodology that FPI came out of

19 the ground with was the technology developed by

20 the Fraud Prevention Bureau under Alan Cates'

21 directorship.

22 Q. Okay. The technology that we're

23 talking about is something called the Safe

24 Provider Program?

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1 A. Correct.

2 Q. And that's the -- that's the idea

3 that you -- that you developed?

4 A. Correct.

5 Q. And is it an idea of FPI or is it an

6 idea of the United Pharmacist Network?

7 A. No. It's the idea of FPI.

8 Q. Okay. Is there a computer program

9 that's called the Safe Provider Program?

10 A. It's a -- the Safe Provider Program

11 is a credentialing program. It's very similar

12 to -- are you familiar with the term "IPA,"

13 Independent Practice Association?

14 Q. Why don't you explain what that is

15 on the record if you want to do that.

16 A. IPA would be a contracting group of

17 health care providers. It's commonly used in

18 managed care and it commonly in the past has been

19 used for a group of physicians. This is quite

20 analogous to an IPA with pharmacies and we -- FPI

21 is part of the credentialing process that is

22 ongoing within the network to give the buyer, in

23 this case the Medi-Cal HMOs in California, the

24 confidence that the network has -- is -- is

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1 screened for and monitored in an ongoing way for

2 fraud -- fraudulent activities.

3 Q. You mentioned the Medi-Cal HMOs

4 would be the buyers. Do you have any Medi-Cal

5 HMOs that are buyers of this product?

6 A. There -- there are several accounts

7 they are competing for, UPNI, but currently, no.

8 Q. All right. And the -- I guess I

9 didn't understand when you -- you mentioned that

10 this is a credentialing program. Is there -- is

11 there some software that FPI has developed that's

12 part of --

13 A. No.

14 Q. No.

15 A. The program is an inspection by an

16 investigator filling out a paper-based

17 questionnaire. That questionnaire then is scored

18 and a risk -- a risk factor is assigned to each

19 individual pharmacy and those with high risk

20 scores are then monitored more closely.

21 Q. Okay. And I assume from your prior

22 answers that none of these inspections by

23 investigators filling out these questionnaires and

24 assigning risk factors is actually taking place

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1 yet?

2 A. We are now in the phase of educating

3 the network as to what the program is going to be.

4 So there's a series of programs for the 70

5 pharmacies to bring their people in and Alan Cates

6 is giving them talks on what the program consists

7 of and what we're looking for. It's more of an

8 educational process.

9 Q. So the answer to my question is no,

10 you haven't begun any of these investigations?

11 A. We haven't started any

12 investigations, correct.

13 Q. Okay. Now, are you actually

14 yourself, sir, familiar with the investigations

15 that have been -- that have taken place to date by

16 the Medi-Cal Fraud Prevention Bureau?

17 A. I'm somewhat familiar.

18 Q. Okay. Just from reading the

19 newspapers?

20 A. No. I've actually gone out on some

21 investigations with -- with the investigators.

22 Q. All right. And do any of those

23 investigations that you're familiar with,

24 personally familiar with, involve pharmaceutical

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1 manufacturers?

2 A. The investigation that I went out on

3 involved medical supplies.

4 Q. Okay. And so the answer is no, it

5 doesn't involve pharmaceutical --

6 A. Not --

7 Q. -- manufacturers?

8 A. My visit did not.

9 Q. Okay. And -- and you mentioned

10 before how the Medi-Cal Fraud Prevention Bureau

11 has -- has successfully undertaken prosecutions of

12 physicians and pharmacists; correct?

13 A. Correct.

14 Q. Are you familiar with any Medi-Cal

15 fraud investigation that involves the

16 pharmaceutical industry?

17 A. The short answer is no.

18 Q. All right. And does any of your

19 work in connection with FPI involve negotiating

20 contracts with pharmaceutical manufacturers?

21 A. No.

22 Q. Negotiating with PBMs?

23 A. No.

24 Q. Negotiating with HMOs?

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1 A. No.

2 Q. Has it given you any more

3 familiarity with rebates, pharmaceutical rebates?

4 A. It's given me -- it's given me a

5 more in-depth street knowledge of how -- of the

6 effects of rebates on the market.

7 Q. How so?

8 A. It's a -- again, this is a big

9 subject.

10 There are a number of activities at

11 the pharmacy level in particular where fraudulent

12 players have learned how to game the system. The

13 system consists of obtaining external sources for

14 evidence, and our investigators will look at the

15 books for a vendor, say a durable goods company, a

16 medical transportation company, a pharmacy, and

17 they will determine what the -- what the -- what

18 the vendor says that they sold and billed for and

19 then we will go back to the supplier and determine

20 whether or not the wholesaler actually delivered

21 the product to the vendor. We will then go to the

22 patients who received the supply and determine

23 whether or not the patient actually received it.

24 Am I going off course here for you?

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1 Q. What you're doing -- based on what

2 you said before, you're using "we." Okay. None

3 of the things that you just described actually

4 involve you; correct?

5 A. Well, except for this one

6 investigation that I was involved in --

7 Q. Okay.

8 A. -- that's correct.

9 Q. Well, then explain for me that

10 investigation so I understand completely what

11 that -- what that involved.

12 A. This -- this followed pretty much

13 what I've just told you. We -- it was a durable

14 goods company.

15 Q. What was the name of the company?

16 A. As I recall, it was called the

17 Golden Supply Company or something like that. It

18 was in San Francisco. And it mostly consisted

19 of -- it was durable goods, which is where the --

20 where the highest percentage of fraud occurs

21 within the Medi-Cal program. And this happened to

22 be a business that served for the most part the

23 Russian immigrant community in San Francisco, and

24 we were involved in an investigation where you

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1 looked at -- the investigators. I was not part of

2 this. They looked at the -- at the company

3 initially, and out of that process a high risk

4 score was attached to the -- to the vendor, and

5 then I came back in with the investigator and

6 spent a day. We looked at the books of the vendor

7 and his bank statements. We then went and visited

8 with some of the patients who were -- who had

9 received the supplies. We had previous -- the

10 investigator had previously authenticated with the

11 wholesaler that they had, in fact, delivered

12 inventory.

13 Q. What was the product?

14 A. Well, durable goods are usually

15 things like oxygen supply for patients at home,

16 wheelchairs. Interestingly enough, the most

17 frequent area of fraud in Medi-Cal is adult

18 diapers.

19 So determining that, in fact, these

20 supplies have been delivered to this -- this

21 company by the wholesaler was one of the steps.

22 And then we went to the physician,

23 who was one of the more prominent prescribers, and

24 asked, Did you prescribe these entities? The way

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1 the process works is the most common source for  
2 fraud in -- in the Medi-Cal or in any aspect of  
3 medicine is identity theft, so that supplies are  
4 billed to a person who does -- isn't aware that  
5 they are occurring or physicians are reported to  
6 have prescribed drugs that they didn't prescribe.  
7 So you're looking throughout the  
8 system for evidence of identity theft as the start  
9 of the criminal investigation under -- under the  
10 Fraud Prevention Bureau.  
11 Q. How much time did you spend on this  
12 one investigation you're talking about?  
13 A. I spent a day and a half.  
14 Q. Have you done any other  
15 investigations?  
16 A. No.  
17 Q. The pharmacists that you have signed  
18 up as part of the United Pharmacist Network, you  
19 mentioned tried to do some auditing to prevent  
20 fraud, those -- those types of things.  
21 Is there a problem with fraud in  
22 your experience at -- at the pharmacy level?  
23 A. Yes. Would you like that  
24 quantitated?

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1 Q. Yes, sir.  
2 A. Fraud in health care overall is  
3 about 10 percent. About 10 percent of all  
4 transactions in health care are by FBI figures  
5 siphoned off into fraudulent activity. The  
6 incidence of fraud at the pharmacy level can run  
7 somewhere north of 40 percent and the incidence of  
8 fraud in durable goods can run up to 90 percent of  
9 the transactions are fraudulent.  
10 Q. Did -- have you had any -- have you  
11 had any discussions with any of the -- with any of  
12 the folks that are -- that are pharmacies that are  
13 plaintiffs in this case about the fraudulent  
14 activity that you're talking about?  
15 A. I'm sorry.  
16 Q. Have you had -- for example, are you  
17 aware of any fraudulent situations that involve  
18 CVS and Rite Aid, for example --  
19 A. Oh, no, not at all.  
20 Q. -- Mr. Einhorn's clients? Okay.  
21 Are you --  
22 A. CVS -- CVS for the most part is not  
23 a California company. Rite Aid is. But generally  
24 speaking, these are not involving the chains.

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1 Q. All right. So these are --  
2 A. Fraud does occur at chains, but it's  
3 a different kind. This is more of a street crime  
4 type level crime.  
5 Q. What's the fraud that occurs in the  
6 chain that you're become familiar with?  
7 A. Well, it usually is complex  
8 litigation involving reimbursement rules for  
9 Medicare. I'm not personally familiar with it  
10 other than what I'd read in the paper. That's not  
11 our area of expertise.  
12 Q. Okay. All right. The second group  
13 that you've become involved in since your last  
14 deposition is something called Illumination  
15 Medical, Inc., which in your report on Pages 5 and  
16 6 you state that you currently own a privately  
17 held company --  
18 A. Did you want this back?  
19 Q. No. That will be one of the  
20 exhibits.  
21 A. Should from now when I'm finished  
22 give this to the reporter?  
23 Q. We'll just have a stack right here.  
24 A. Okay.

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1 Q. That's fine. Even this one, too.  
2 Your report you'll probably --  
3 A. Sorry to step on your lines. I've  
4 broken my -- my goal already.  
5 Q. Okay. The Illumination Medical,  
6 Inc. You state in your report that you currently  
7 own a privately held company, Illumination  
8 Medical, Inc. The company specializes in data  
9 mining. Illumination Medical analyzes medical and  
10 pharmacy claims to predict serious chronic illness  
11 in a population of beneficiaries before the  
12 disease process becomes catastrophic."  
13 How much of your time do you spend  
14 on Illumination Medical, sir?  
15 A. I'd say I spend about 60 -- 60  
16 percent of my time, roughly.  
17 Q. Do you -- in your resume, you state  
18 that you're the partner and chief operating  
19 officer since -- from 2003 to the present?  
20 A. Correct.  
21 Q. Do you have any other employees?  
22 A. No. Just my partner and I.  
23 Q. Who's your partner?  
24 A. Her name is Lillie DuVale,

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1 D-u-V-a-l-e.  
 2 Q. And --  
 3 A. Capital V.  
 4 Q. Is this -- is this still in the  
 5 startup phase?  
 6 A. It is. But we have clients. I'm  
 7 not sure when startup goes to not. We aren't  
 8 drawing much in the way of money from it yet. So  
 9 I guess it's startup.  
 10 Q. Okay. And can you tell us more  
 11 what -- what you mean by saying that your company  
 12 specializes in -- in data mining?  
 13 A. This is a very -- this is a -- this  
 14 is a very important area within health care today.  
 15 For the most part, all of the  
 16 techniques that we've used in the past to try to  
 17 control medical costs, including prior  
 18 authorizations and authorizations for referrals  
 19 and authorizations for hospitalizations and the  
 20 whole list as it goes on, has not worked. And the  
 21 payers in the system, the insurance companies, the  
 22 employers, have had self-funded trusts called  
 23 ERISA, E-R-I-S-A, trusts, and the labor unions  
 24 that have Taft-Hartley trusts, T-a-f-t-

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1 H-e-a-r-t-l-y trusts, are now looking at a  
 2 different approach, and that approach is to build  
 3 off the realization that 1 percent of any  
 4 beneficiary pool produces most of the cost. And  
 5 there's an interesting finding, the 5 percent who  
 6 have chronic illnesses that will likely lead to  
 7 high cost and being able to intervene before they  
 8 do so.  
 9 And that's what our company does.  
 10 We work as a consultant to consultants. We put  
 11 all of the medical and pharmacy claims data into a  
 12 data warehouse and then we model that data to be  
 13 able to predict who's going to get sick and who's  
 14 likely to have catastrophic complications.  
 15 Q. And when you say you try to figure  
 16 out who's going to get sick and who will have  
 17 catastrophic complications, do you do that on an  
 18 individual person basis or you try to look at  
 19 certain -- certain groups, like an actuary, I  
 20 guess I'm thinking?  
 21 A. Well, an actuary looks backwards.  
 22 We look forwards. That -- that's the big  
 23 difference between us and actuaries.  
 24 What I've described to you sounds

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1 more complex than it really is. The reality is  
 2 most of the cost in health care can be identified  
 3 as occurring within a small group of people that  
 4 are sick, people with congestive heart failure,  
 5 people with asthma, people with hypertension. So  
 6 if you can identify within a population of  
 7 beneficiaries all those individuals who carry that  
 8 diagnosis and then bounce the care that those  
 9 people are receiving off of national recognized  
 10 standards, for instance, how do you treat  
 11 congestive heart failure as indicated by the  
 12 American Heart Association, and when you find that  
 13 people who carry these diagnoses are not receiving  
 14 therapy within those guidelines, that becomes a  
 15 target for intervention.  
 16 Q. How do you go about identifying what  
 17 is the small group of people that are likely to  
 18 get sick?  
 19 A. I put the population through a  
 20 series of filters on the computer. I look at  
 21 total cost that they've generated in the past.  
 22 And in general I'm looking for not people that  
 23 generate a hundred thousand dollars in the past  
 24 year, but around 10,000. I look at their -- what

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1 drugs they're receiving and by class identify  
 2 whether or not there are drugs that are likely,  
 3 that -- that -- instances where generics are more  
 4 appropriate than brand. I look at the -- what are  
 5 call HEDIS criteria, that's H-E-D-I-S, and it's --  
 6 it stands for Health Employer Data Information  
 7 Sets.  
 8 And these are criteria that  
 9 employers use to rate one health plan as opposed  
 10 to another for quality.  
 11 So there are all sorts of criteria  
 12 that you can look at, including whether children  
 13 are getting immunized, women are getting Pap  
 14 smears and mammograms. I look for instances  
 15 within chronic disease. For instance, we just  
 16 completed an analysis, and I look at all the  
 17 patients within a plan that have atrial  
 18 fibrillation, which is a condition of -- where the  
 19 heart beats irregularly. And I will then look to  
 20 see whether or not those patients are on  
 21 anticoagulants. That's important, because an  
 22 irregular heartbeat precipitates blood clots in the  
 23 heart that break away and then produce strokes or  
 24 emboli to the kidneys or to some other -- produce

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1 some other catastrophic complication.  
 2 So I look for all of the patients,  
 3 all of the beneficiaries in the plan who carry  
 4 diagnosis of atrial fibrillation who are not on  
 5 anticoagulants, and of those who are on  
 6 anticoagulants, are they getting blood-clotting  
 7 studies done on at least a monthly basis. Now, I  
 8 don't know the results of the blood-clotting  
 9 study. I just know that the health plan paid for  
 10 the test.  
 11 Likewise, I'll look at congestive  
 12 heart failure. The national standards for therapy  
 13 are that these patients are on ACE inhibitors,  
 14 A-C-E inhibitors, and beta blockers. If they're  
 15 not, the recidivism rate for visits to the  
 16 emergency room are exceedingly high. And sudden  
 17 death as well.  
 18 Q. Aren't there confidentiality  
 19 concerns in connection with employers sharing that  
 20 information?  
 21 A. There are absolutely -- the issue is  
 22 known as HIPAA, which is H-I-P-P-A, which is the  
 23 Health Insurance Portability Act, also known as  
 24 the Kennedy-Kassebaum Act, and within the

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1 structure of that we function as a business  
 2 associate for the plan. So the plan creates a  
 3 confidentiality structure and we function within  
 4 their umbrella as a subcontracting business  
 5 associate. That's well recognized within HIPAA.  
 6 Q. Okay. How many plans have you done  
 7 this type of analysis for?  
 8 A. We've done two thus far. We have  
 9 several more on the way. Our -- our focus is  
 10 generally on plans that are 10,000 or so.  
 11 Usually -- our first two was a multistate employer  
 12 for supplying electrical products and the second  
 13 was a union in California. We have several other  
 14 unions that we anticipate bringing aboard and we  
 15 have a -- we also market heavily into ERISA trusts  
 16 that would typically be school districts or  
 17 hospitals.  
 18 Q. Sir, in the instances where  
 19 you've -- the two instances where you've made this  
 20 type of analysis, I assume you prepare a report?  
 21 A. I do.  
 22 Q. And then there's a proposed plan of  
 23 intervention for those folks --  
 24 A. There is.

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1 Q. -- that are high risk?  
 2 A. Go ahead.  
 3 Q. Here's my question. How do you know  
 4 that the employers, in fact, intervene by giving  
 5 them, let's say, the medical care as opposed to  
 6 working them towards termination or something like  
 7 that?  
 8 A. Oh. I don't know how the plan would  
 9 administrate. That would be --  
 10 Q. Be wrong; right?  
 11 A. Almost -- I can't imagine that they  
 12 would use it for that nefarious purpose, the  
 13 reason being that most of these are long-term  
 14 employer arrangements. Certainly the Taft-  
 15 Hartleys wouldn't be an option with the unions.  
 16 Q. Does -- does any of this work that  
 17 you've done with -- with Medical Imaging, does  
 18 that involve negotiating contracts with  
 19 pharmaceutical manufacturers?  
 20 A. No.  
 21 Q. Negotiating with PBMs?  
 22 A. No.  
 23 Q. Negotiating with HMOs?  
 24 A. No.

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1 Q. Rebates, exclusive contracts,  
 2 anything like that?  
 3 A. No.  
 4 Q. Oh, I'm sorry. The name of the  
 5 company is Medical Illumination.  
 6 A. Illumination.  
 7 Q. You -- you knew what I meant.  
 8 A. I do.  
 9 Q. I'm sorry.  
 10 A. Illumination Medical.  
 11 Q. Okay. How do you divide your time  
 12 currently between the Fraud Prevention Institute,  
 13 Medical -- I'm sorry, Illumination Medical and  
 14 PCN?  
 15 A. I function at PCN as a part-time  
 16 medical director, which is about 20 percent of my  
 17 time.  
 18 Q. Do you have an office there?  
 19 A. I have a cubicle.  
 20 Q. Do you have a staff of any kind?  
 21 A. No. I -- my area of responsibility  
 22 at the company is primarily the pharmacy and  
 23 therapeutics committee and the quality assurance  
 24 activities, and there are staffs for those

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1 committees, but I really don't manage those  
2 staffs. And the one other area that I am involved  
3 in in the company is we --we have a program called  
4 Med Intelligence, which if you went out on the Web  
5 and pulled it off, you probably are aware of, and  
6 it gives counsel to physicians as to the  
7 medications that patients are on and it -- those  
8 communications are letter based and all the  
9 letters that go out are over my signature. And  
10 the staff for that activity, also I don't manage  
11 that staff.

12 Q. Okay. Why would a -- why would PCN  
13 sent out letters under -- as part of Med  
14 Intelligence to physicians?

15 A. There's a lot that goes on in the  
16 life of a patient that doctors don't know about.  
17 For instance, patients are seen by multiple  
18 doctors and are prescribed medications by multiple  
19 doctors and frequently a doctor isn't aware that a  
20 patient is taking a certain drug that would  
21 interact with a drug that he may have prescribed.

22 Likewise, one of the biggest  
23 problems in health care is noncompliance on the  
24 part of the patient, such that the doctor gives a

1 Q. Okay. I'm just -- I'm just trying  
2 to get your best estimate as to whether or not --  
3 A. Hardly any.  
4 Q. Hardly any? Once, twice?  
5 A. The total number of letters sent out  
6 each month are in the thousands and -- high end  
7 thousands. And if we sent out two or three for  
8 that, I'd be surprised.

9 Q. But they'd be under your signature?

10 A. Yes, but the signature is automated,  
11 so I don't see every single letter that goes out.

12 Q. Okay. But you are -- you are aware  
13 of the fact that PCN does send out letters for  
14 products when a physician does prescribe a product  
15 that's off formulary; correct?

16 A. Again, I don't want to be absolute,  
17 but I'm just saying it's virtually -- it's not  
18 common. The most common thing that the letters  
19 involve is are you aware that this patient has  
20 another drug that they're on that the literature  
21 would indicate is contraindicated for this patient  
22 to be taking.

23 Q. Doctor, I'm not trying to figure out  
24 what the most common is. I want to get your

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1 patient a prescription and for whatever reason the  
2 patient doesn't get it filled at the pharmacy.  
3 And so our ability to communicate to the  
4 prescribing physician that his patients, say, with  
5 congestive heart failures didn't get their  
6 prescriptions for ACE inhibitors filled is very  
7 helpful to that doctor.

8 Q. Do you also send out letters, sir,  
9 to physicians where they prescribe a product that  
10 is not on the PCN formulary?

11 A. That's infrequent, because just  
12 about every drug is on the formulary. It may be  
13 at the third tier. But those types of  
14 restrictive, almost enforcement activity that I'm  
15 sure we'll talk at about at length today is not  
16 something we generally do much of.

17 Q. How frequently have you sent letters  
18 like that for -- to physicians where they  
19 prescribe a product that's off formulary?

20 A. Well, again, the only -- most  
21 everything is taken care of at the -- at the  
22 dispensing site with the pharmacy. As I  
23 mentioned, third tier for our formularies  
24 encompass just about all drugs.

1 understanding --

2 A. Yes.

3 Q. -- as to whether or not you're aware  
4 that letters are sent out to physicians that  
5 prescribe products that are off formulary under  
6 your signature.

7 MR. COHEN: Objection. Asked and  
8 answered.

9 A. Again, I'm sure if we went through  
10 the whole list, we could find some of those  
11 letters. It -- it doesn't leap to my mind that we  
12 do it. I can't recall instances where it has  
13 happened, but I'm sure that occasionally you have  
14 it.

15 BY MR. DOBIE:

16 Q. Okay. How often does the P&T  
17 committee meet at PCN since -- let me back up.

18 At the time you had your deposition  
19 in June of 2002, the P&T committee had not met.  
20 Since June of 2002 --

21 A. Right.

22 Q. That's correct. Since June of 2002,  
23 has the PCN P&T committee met?

24 A. Yes.

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1 Q. On how many occasions?

2 A. We meet -- we've been meeting now

3 for about a year and we meet roughly on a

4 quarterly basis.

5 Q. So since the beginning of '03,

6 you've been meeting?

7 A. Yes.

8 Q. And you've had how many meetings?

9 A. We've --

10 Q. Four or five?

11 A. I'd say we've had about four or five

12 meetings.

13 Q. Who are the other members of the P&T

14 committee at PCN?

15 A. There's about seven or so members.

16 It consists of both pharmacists and -- academic

17 pharmacists and physicians.

18 Q. Are any of the staff folks at PCN

19 that you mentioned members of the PCN P&T

20 committee?

21 A. They're not members. I'm the only

22 member of the committee. They -- they serve a

23 support function for it, frequently research the

24 drugs and make presentations to the committee.

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1 Q. I'm sorry. I thought you said there

2 were seven members of the committee.

3 A. There are.

4 Q. Okay. Then you -- did you say

5 you're the only member?

6 A. I'm the only one from PCN.

7 Q. I understand. Okay. So there's --

8 you're the only member from PCN and the other six

9 members are academic --

10 A. Are external.

11 Q. Understood. And why is the

12 committee organized in that -- in that fashion?

13 Why don't you have the staff members as -- as

14 members of the P&T committee?

15 A. That's a good question. I think a

16 lot of it has to do with tradition. If you -- if

17 you study the history of formularies, they started

18 as -- in hospitals. This was back in the '50s.

19 And it was where the hospital determined it

20 couldn't stock every drug. So there was a limited

21 number of drugs in the pharmacy and they

22 instituted P&T committees consisting of members of

23 the medical staff that would consult as to what

24 drugs were in the -- in the formulary for the

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1 hospital and it's pretty much stayed that way to

2 the present. It's nice to have outside physicians

3 and pharmacists looking in on this process.

4 Q. How many -- how many -- of the six

5 other members, how many are physicians?

6 A. All but one.

7 Q. Okay. So you've got -- you've got

8 five physicians. Are any of them OB-GYNs?

9 A. One.

10 Q. Who is that?

11 A. Victor Chen, C-h-e-n, is an OB-GYN

12 physician in Sacramento who's also a professor at

13 UC Davis.

14 Q. Are any of them primary care

15 physicians, the other four?

16 A. One is an emergency room physician.

17 I'm just -- I'll work my way through the list

18 here.

19 One is an endocrinologist. One is a

20 rheumatologist. One is a pediatrician. I think

21 the pediatrician probably would be the primary

22 care. And then, of course, the internists with

23 subspecialties also function as primary care.

24 Q. There's one internist?

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1 A. Well, no. The rheumatologist --

2 Q. Oh, the rheumatologist.

3 A. -- the endocrinologist, and -- and

4 you could classify the emergency room physician as

5 a primary care physician.

6 Q. All right. So the -- you have these

7 meetings, four or five meetings a year. How much

8 of your time, if you were to divide it up between

9 the P&T committee and the QA group and Med

10 Intelligence that we talked about -- how would you

11 say your time is roughly divided between those

12 three groups?

13 A. I'd say about a third, a third, and

14 a third would be rough.

15 Q. And since you have actually had the

16 P&T committee up and running, has PCN created its

17 own formulary?

18 A. We have.

19 Q. And when did PCN create its own

20 formulary?

21 A. When the P&T committee was formed.

22 That was part of the process for us to bring

23 the -- bring the formulary back inhouse.

24 Q. All right. So that would have been

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1 the beginning of 2000 --

2 A. Early -- early --

3 Q. Let me finish, if I could. The

4 beginning of 2003?

5 A. Correct.

6 Q. All right. And as -- as part of the

7 creation of a formulary, did members of the P&T

8 committee meet with any pharmaceutical

9 manufacturers?

10 A. The P&T committee does not meet with

11 pharmaceutical manufacturers.

12 Q. And why not?

13 A. It's just not part of the process.

14 We -- we meet -- let me explain the meeting.

15 The meeting is in a virtual

16 environment, so people are in attendance from all

17 over the country but nobody's in Sacramento. We

18 work off of conference calls and websites. And

19 the staff will make a presentation generally

20 concerning four new drugs and we will hear a

21 presentation of the scientific information

22 available on the drug and then at the end make a

23 decision as to whether -- as to what category the

24 drug's going to fall in.

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1 Q. Okay. So how about you yourself; as

2 medical director of PCN, have you met with medical

3 manufacturers as part of your responsibility on

4 the P&T committee?

5 A. Occasionally I will attend a

6 presentation by a pharmacy manufacturer on one of

7 their new products as it comes through. It --

8 it's more for me a lunch meeting that -- that is

9 primarily for the consulting pharmacists within

10 the company and I will just sit in on it

11 occasionally.

12 Q. These -- these are people that are

13 detailing new products; right?

14 A. They're detailing new products.

15 Q. Okay. But have you met with -- with

16 pharmaceutical manufacturers in connection with

17 the establishment of the PCN formulary?

18 A. No.

19 Q. All right. How about the -- tell me

20 more about what the -- what the QA, quality

21 assurance, group does at PCN.

22 A. When -- when a health plan contracts

23 out for the management of their pharmacy benefit,

24 the contracted entity has to conform to the

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1 quality assurance criteria for the health plan

2 for the health plan to be able to be certified by

3 the NCQA. That's the National Committee for

4 Quality Assurance. This is certification that

5 this independent group gives. It's kind of like

6 the Good Housekeeping Seal of Approval. And we

7 have to function within the guide -- this is a

8 rather complex infrastructure, but we have to

9 function within the quality guidelines for the

10 health plan so we don't jeopardize their status

11 with the NCQA.

12 So we run a continuous monitoring on

13 all of the activities of the PBM to determine

14 things like how long people have to wait when they

15 call in on a phone or how long a delay might exist

16 for a special request from a prescribing physician

17 or if we have downtime on our computer systems,

18 how much is it per month. Those sorts of things

19 are the ongoing monitoring of the quality of the

20 service that we provide as a PBM and then it feeds

21 directly into the NCQA documentation for the

22 various health plans that are our clients.

23 Q. So you have to -- PCN, which is a

24 pharmacy benefit administrator, has to be

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1 certified by the NCQA in order for people's health

2 plans and things to use it, basically?

3 A. Two corrections. First, PCN is a

4 PBM. It's a pharmacy benefit manager. It's just

5 the title within health care. And no, we are not

6 certified by NCQA. The health plan is. We have

7 to conform to the health plan's quality criteria

8 on management systems or we could jeopardize the

9 health plan's NCQA certification.

10 It's very analogous to the issue we

11 discussed earlier dealing with HIPAA. PCN is is

12 not HIPAA qualified. It functions as a business

13 associate to the health plans that are the HIPAA

14 compliance entity.

15 Q. So there's -- there's certain

16 standards that you as the PBM have to meet in

17 order for the health plan to be certified by the

18 NCQA?

19 A. That's correct.

20 Q. All right. And -- and you mentioned

21 how long somebody waits on the phone and things

22 like that.

23 A. Correct.

24 Q. Are there -- are there standards for

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1 this that are -- that are promulgated by the NCQA?  
2 A. The NCQA -- and you can go out and  
3 look at this. It's a complex process. But they  
4 establish all these various criteria that they  
5 want you to look at to -- so that you're  
6 monitoring for quality within how you administer a  
7 plan or how people get health care delivered to  
8 them and so forth.

9 And the process is not so much  
10 meeting a test score like you have in school. You  
11 know, if you get 90 or better, you get an A -- or  
12 95 and better, you get an A and 85 and up, you get  
13 a B. It's not that way. It is whatever your --  
14 you look at your performance based on your initial  
15 evaluation and then they want to see you close the  
16 loop. That means they -- that you recognize if  
17 there's a problem, you create a plan, and then you  
18 monitor to see if the plan improved performance.

19 Q. Dr. Gibson, to go back to my  
20 question, are there written standards the NCQA  
21 promulgates that you as the PBM try to live by?

22 A. There are criteria published and we  
23 function within those criteria and monitor our  
24 performance based on them.

1 be do we have downtime on our computers, which  
2 would affect the pharmacy's ability to receive  
3 hard and soft edits and things that we'll talk  
4 about later, I'm sure.

5 Q. Okay. Let's go on to another  
6 position that's mentioned in your report.

7 In your current report on your  
8 resume, you state that you've been the president  
9 of the Pacific Development Group from 2000 to the  
10 present; correct?

11 A. Correct.

12 Q. Okay. Now, the report that you  
13 filed in the Duramed case said that you were the  
14 president of the Pacific Development Group  
15 beginning in 1998.

16 Can you explain for me the reason  
17 for the difference?

18 A. No.

19 Q. Okay. When did the Pacific  
20 development group -- was that founded?

21 A. I started it roughly when I left  
22 Omni.

23 Q. But at the time of your last  
24 deposition, you said that you were spending half

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1 Q. Do the -- do the criteria cover all  
2 subjects like the creation of a formulary?

3 A. No.

4 Q. The payment of rebates to plans?

5 A. No.

6 Q. How you handle things like prior  
7 authorizations?

8 A. If we have prior authorizations, how  
9 long does it take to grant them would be a  
10 criteria that would be applied.

11 Q. And what's -- what's the standard or  
12 the criteria that you're trying to meet as it  
13 relates to prior authorization in order to meet  
14 the NCQA standard?

15 A. Generally they try to turn around  
16 prior authorization in a short period of time  
17 during business hours. I don't know exactly, but  
18 I'd say it's within 24 hours.

19 Q. Okay. Are there other examples like  
20 prior authorizations that you can think of that --  
21 that you have to meet under the NCQA criteria?

22 A. Well, again, the criteria we're  
23 trying to meet is the criteria that the health  
24 plan sets for NCQA and another one would typically

1 of your time on the Pacific Development Group.

2 How much of your time are you  
3 spending on the Pacific Development Group now?

4 MR. COHEN: Today?

5 MR. DOBIE: Yes, sir.

6 A. I would say 10 percent of my time.  
7 BY MR. DOBIE:

8 Q. And is it essentially consulting  
9 with physician groups and -- on business issues?  
10 A. No. It's a very specialty-based  
11 consulting practice and it has evolved over the  
12 years.

13 Q. What is it doing currently?

14 A. What's it doing currently?

15 Q. Yes, sir.

16 A. I'm working with a group of  
17 pharmacists that are primarily based at USC in Los  
18 Angeles to explore the development of an infusion  
19 therapy network.

20 Q. And what's an infusion therapy  
21 network?

22 A. Health -- the nature of the  
23 pharmaceutical products is changing. We're going  
24 from pills that people take at home to drugs that

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1 are -- with high potency that require injections.  
2 And your client has one of those products. It  
3 will be Enbrel. But these are products that  
4 require a clinical presence during administration.

5 Q. Okay. And -- and you said that  
6 you're working with the pharmacists at the USC,  
7 University of Southern California University?

8 A. Correct. Not -- not at it. These  
9 are mostly alumni and affiliated with the School  
10 of Pharmacy at USC.

11 Q. Okay. Does -- does the project have  
12 anything to do with the University of Southern  
13 California other than these are alumni?

14 A. It may. The project's evolving at  
15 the present time. It may bear the USC nameplate.

16 Q. So this is a -- this is a project  
17 that is --

18 A. It's a development project.

19 Q. And at this point, what are you  
20 trying to help the pharmacists do as it relates  
21 to, as you -- as you explain it, physicians having  
22 to have a more clinical presence during the  
23 administration of the pharmaceuticals? What's --  
24 what's the interface between your client group,

1 distribute the product, assuming that there was a  
2 prescription from a physician, as opposed to  
3 having the physician give the product?

4 A. In essence, yes.

5 Q. Okay. At the time of your last  
6 report, you had still on your -- your resume that  
7 RxPhysician was from January of 1998 to the  
8 present.

9 Do I take it that RxPhysician  
10 currently is -- at least your involvement has  
11 ceased?

12 A. RxPhysician is inactive.

13 Q. There's -- there's a website that's  
14 out there now. It's still RxPhysician.

15 Do you have any involvement --

16 A. It's not --

17 Q. -- with that?

18 A. It's not ours. At least, I don't  
19 know about it.

20 Q. All right. It sells Viagra, weight  
21 loss drugs, things like that?

22 A. That's not us.

23 Q. That's not you. Okay.

24 With RxPhysician, we spent a fair

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1 the pharmacists, and what you've described before,  
2 which is the need to have doctors have -- have  
3 a -- I guess be more involved with the  
4 administration of pharmaceuticals?

5 A. I don't recall that I said that, but  
6 why don't I back up a little and maybe I can make  
7 this a little clearer.

8 Q. Sure.

9 A. Currently these specialty drugs,  
10 Enbrel being an example, are typically  
11 administered either in the doctor's office or in  
12 the emergency room. There are a lot of problems  
13 that are resulting from that current platform and  
14 the pharmacists are exploring the opportunity to  
15 create their own infusion therapy centers that are  
16 community based.

17 Q. So in essence, replace the doctors  
18 and have the pharmacists provide the infusion  
19 therapy?

20 A. Physicians could be present during  
21 the infusion process, but it has more to do with  
22 how product is distributed.

23 Q. Right. But is the idea essentially  
24 that you'd have the pharmacist be able to

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1 amount of time talking about it in your last  
2 deposition, so I don't want to repeat it. I just  
3 want to make sure I understand something, because  
4 we had some correspondence back and forth with --  
5 with Mr. Cohen trying to make sure that we had an  
6 understanding of -- of some data issues.

7 First, am I correct that the data  
8 that you developed -- let me back up.

9 Tell us generally what  
10 RxPhysician -- what you were trying to do as it  
11 related to the PBA project for RxPhysician?

12 A. We were trying to develop a digital-  
13 based ordering system for prescribing medications  
14 for physicians in the clinical setting.

15 Q. Okay. And there was a study that  
16 was done in this clinic in Santa Barbara and a  
17 study that was done at the Straub Clinic in  
18 Hawaii; correct?

19 A. Correct.

20 Q. And in connection with that study,  
21 you developed certain, I think as you put it in  
22 your last deposition, anecdotal data. Do you  
23 recall that?

24 A. Correct.

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1 Q. And that data was never formalized  
 2 into a report; correct?  
 3 A. No. It was proprietary.  
 4 Q. And -- well, not only wasn't it --  
 5 let me make sure I'm being clear.  
 6 I understand it was proprietary, but  
 7 you never prepared a report with that data either;  
 8 correct?  
 9 A. Correct.  
 10 Q. And you don't have that data here  
 11 today?  
 12 A. No, I do not.  
 13 Q. All right. And do you know who has  
 14 the data?  
 15 A. I have the data.  
 16 Q. Oh, you do have the data?  
 17 A. It's in my head.  
 18 Q. Oh.  
 19 A. I know the outcome of those  
 20 evaluations of physician work environments.  
 21 Q. All right. If somebody wanted to  
 22 test the information, to look for themselves at  
 23 the information that came from the study at the  
 24 Straub Clinic in Hawaii or the Santa Barbara

1 prescribing. And a number of the -- of the  
 2 electronic medical records companies that wanted  
 3 to add a digital ordering module to their product  
 4 would have done those kind of studies.  
 5 Q. Potentially a big market.  
 6 A. The potential market was great. It  
 7 was an incredible flop.  
 8 Q. Okay. None of these companies ever  
 9 brought a product to market; correct?  
 10 A. No. Almost everybody brought a  
 11 product to market. The issue wasn't having  
 12 technology that worked or even technology that  
 13 doctors would use. The problem was being able to  
 14 make it -- the business model work.  
 15 Q. Okay. We -- we covered some of that  
 16 in your last deposition, so I don't want -- I  
 17 don't want to repeat all that.  
 18 The anecdotal information that  
 19 you -- that you gathered, you mentioned last time  
 20 that you hadn't done any sort of double blind  
 21 study or as you said perfect science. How many  
 22 physicians were in the study that -- that was done  
 23 at the Santa Barbara Clinic?  
 24 A. We had about 10 to 15 physicians at

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1 Clinic, is there any source or any information by  
 2 which someone could test that information?  
 3 A. No. Let me just back up.  
 4 I suppose you could talk to some of  
 5 the physicians that were involved in the -- in the  
 6 project, but that you -- you as an -- a  
 7 dispassionate observer that would want to go and  
 8 read about it, you -- you wouldn't. It's not  
 9 published.  
 10 Q. Is there -- is there any other  
 11 published literature that you're familiar with  
 12 that has done a study like what you did at  
 13 RxPhysician?  
 14 A. I think just about every one of the  
 15 digital-based ordering companies did similar type  
 16 studies to be able to develop their products.  
 17 Q. Okay. Did any of those -- talking  
 18 about the digital-based ordering companies. Who  
 19 are those companies?  
 20 A. Well, most of them now are defunct.  
 21 But one was called IScribe. Another was called  
 22 EPhysician. WebMD was -- at that time was called  
 23 Healthion. That was a predecessor. They -- they  
 24 merged into WebMD. Did a lot of work on digital

1 the Santa Barbara Clinic and a similar number at  
 2 the Straub Clinic. And if I -- if may, let me  
 3 just say that that was the second generation of  
 4 our work. We did -- the first generation was in  
 5 Sacramento, where we -- where we deployed our  
 6 first effort, and then the round with Straub and  
 7 the Santa Barbara Clinic was the second round.  
 8 Q. What was the -- you didn't tell me  
 9 about that in your last dep, I don't believe.  
 10 What was the clinic in Sacramento?  
 11 A. It wasn't a clinic. This was in  
 12 individual physician offices. We were dealing --  
 13 and I won't go into great detail here, unless you  
 14 want me to, but the first generation of this was  
 15 with wide-area network infrastructure for the  
 16 handheld PDA devices, and that consisted of using  
 17 cellular phone technology to link the handheld  
 18 device to -- to the system.  
 19 We -- that was -- that was not -- we  
 20 determined that that technology was not going to  
 21 work because there's a lot of -- if you have a  
 22 cell phone, you know that there's a lot of black  
 23 holes with cell phones, where they just won't  
 24 work. And that was what we discovered.

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1 So in the Santa Barbara Clinic and  
2 in the Straub Clinic, we deployed with a local-  
3 area network which was wireless, and that  
4 consisted of communication to a server within the  
5 clinic using wireless connectivity within the  
6 clinic itself.

7 Q. How many physicians were in the  
8 Sacramento study?

9 A. About 10 to 15. I don't recall the  
10 exact number. Mostly primary care.

11 Q. And in Santa Barbara with the --  
12 with the product, did you have any sort of a lead  
13 physician that you were working through?

14 A. We worked with the department of  
15 ambulatory care, and I'd say I worked with all the  
16 docs down there. I spent a fair amount of time in  
17 Santa Barbara and I would spend time in their  
18 offices. I spent time with their nurses. I spent  
19 time with the pharmacists that received the  
20 communications. And through that I got a feel for  
21 how the flow of a practice works, how much time  
22 was spent on the prescribing part of the practice  
23 and how we could improve that using electronic  
24 data.

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1 Q. The department of ambulatory care  
2 that you mentioned --

3 A. It was -- the community medicine  
4 department was its exact name.

5 Q. And did you have a contract with the  
6 community medicine department?

7 A. No, we didn't have a contract. They  
8 permitted us to come in and use the technology, in  
9 that they were interested it as well. They  
10 were -- they were intrigued by whether this would  
11 improve the practice within their clinic.

12 Q. Who was your primary contact in that  
13 facility?

14 A. Well, let's see. The CEO of the  
15 clinic at that time -- I have to go back in my  
16 records. But we worked through the clinic  
17 administration, the CEO of the clinic and the  
18 chief operating officer of the clinic and the  
19 chief information officer of the clinic, because  
20 we were installing information technology.

21 Q. So when -- so when you went in to  
22 pitch the RxPhysician.com product, the pitch was  
23 in essence to the administrators?

24 A. Correct. And let me correct you on

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1 one item there.

2 It wasn't the pitch to sell a  
3 product to them. We provided all of the  
4 technology, all the software, all the support,  
5 free. This was -- our -- our interest was to see  
6 if we could develop a system that they'd actually  
7 use and it would help in their practice.

8 Q. How long did the project go on at  
9 the --

10 A. For about two months.

11 Q. Right.

12 A. Six weeks to two months.

13 Q. And at the end of the two months,  
14 did the administrators ask you for a report of any  
15 kind?

16 A. No.

17 Q. They just said, Okay. We've been  
18 using your technology. You've taken our time --

19 A. We collectively determined that it  
20 wasn't ready for show time.

21 Q. Okay. And when you say  
22 "collectively," did that include the  
23 administrators at the community medical --

24 A. Yes.

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1 Q. -- group?

2 A. Yes. It was -- it was apparent to  
3 everyone involved that this -- this -- rather than  
4 improving productivity, it decreased productivity  
5 for the physician and there was not any financial  
6 benefit to the physician that resulted from that  
7 inhibition -- or that reduction in productivity.

8 Q. All right. And then the Straub  
9 Clinic in Hawaii. Was that again a similar-type  
10 deal where you would talk to the administrators  
11 in --

12 A. Right.

13 Q. -- the first instance? Who -- who  
14 were the administrators of the Straub Clinic that  
15 you were dealing with?

16 A. I'm sorry. I'd have -- I'd have to  
17 go back in -- in my records on that. But we  
18 were -- we were more -- we were multilocation with  
19 Straub instead of one location at the Santa  
20 Barbara Clinic. We -- we were -- Straub is -- has  
21 clinical facilities throughout all of Hawaii. So  
22 all five islands they have clinical facilities.  
23 And we were involved in -- we were -- we were --  
24 we were mainly in the Honolulu area. But we -- we

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1 had -- we deployed in three or four different  
2 clinical settings and all of it was on the local-  
3 area network infrastructure. And there was a  
4 broader spread of the background of the physicians  
5 involved. We had pediatricians, we had family  
6 physicians, we had some specialists in internal  
7 medicine --

8 Q. How about --

9 A. -- as I recall, endocrinology.

10 Q. How about OB-GYN? I'm sorry.

11 A. I think we might have had one OB-GYN  
12 doc.

13 Q. Do you recall that or --

14 A. I don't recall clearly. But I  
15 recall we visited with the OB-GYN department and I  
16 believe we had one doc that came up on the system.

17 Q. Okay. And then similar result with  
18 the Straub Clinic in Hawaii as in Santa Barbara?

19 A. As far as the outcome?

20 Q. Yes, sir.

21 A. Correct.

22 Q. And did the Straub Clinic in Hawaii  
23 ever ask you for a report in terms of --

24 A. No.

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1 Q. Let me finish. -- how the -- how  
2 the project had gone?

3 A. No.

4 Let me just say one other thing on  
5 that. Hawaii is an interesting place. It's not  
6 like --

7 Q. For many reasons.

8 A. Yes. And it tends to have  
9 monopolies and the insurance company -- health  
10 insurance company over there that's -- that  
11 dominates Hawaii is called HMSA, which is really  
12 the Blue Cross plan, and they elected to go with a  
13 contract with a company called All Scripts that  
14 was exploring digital prescribing. And so it --  
15 not only did we not feel that our technology was  
16 ready for deploying. We -- we would then have had  
17 to compete heads up with All Scripts and HMSA and  
18 we just -- it was apparent that we should pull the  
19 plug.

20 Q. Did -- did All Scripts -- is that  
21 something that was owned by HMSA?

22 A. No. All Scripts is a company --  
23 it's publicly traded. It's out of Illinois, close  
24 to your home base, and I think they lost their

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1 shirt on this project in Hawaii.

2 Q. Do you know whether or not All  
3 Scripts ever put the project in place with more  
4 than one -- let's say 10 or 15 physicians?

5 A. It's my understanding they did and  
6 they did it with -- with a contract with HMSA, and  
7 I think it was a performance-based contract. So  
8 that if the physicians would use it, they would  
9 get paid. And I don't believe -- I'm not privy to  
10 any of the details of how it went. I just have  
11 heard.

12 Q. Well, did you hear the physicians  
13 didn't use it and so they didn't get paid?

14 A. I heard that it was deployed and the  
15 equipment was delivered, but the actual number of  
16 scripts that went through the system were  
17 disappointing.

18 Q. The process or the project that you  
19 did at the Straub Clinic in Hawaii, how many weeks  
20 did that go on?

21 A. Oh, that was a couple of months.

22 Q. And in the process of the -- of it  
23 going on, tell me what kind of -- and this is true  
24 for Santa Barbara. You don't even need to

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1 distinguish between Santa Barbara or Hawaii.

2 What would be the -- generally  
3 speaking, how would the data flow from the  
4 physicians to make it back to you and your -- your  
5 partner at RxPhysician.com?

6 A. Well, all the transactions went  
7 through a server and we were online with that  
8 server.

9 Q. Okay. So you could -- you could see  
10 through -- through monitoring the server what  
11 physicians were doing?

12 A. Correct.

13 Q. All right. I think I understand  
14 why -- so it's not like physicians are filling out  
15 surveys of how they like it or things like that?

16 A. No. We were -- we were real time.  
17 And the real essence was we roughly knew how many  
18 scripts the docs were writing every day. We knew  
19 roughly what they were writing for. Because  
20 that's how we loaded up the system. We didn't  
21 load it up with every drug that had an NDC code.  
22 And we could monitor percentage of usage based on  
23 that.

24 Q. Okay. And what -- generally

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1 speaking, what was the percentage usage in the --  
2 in the Straub Clinic in Hawaii?  
3 A. It varied by doctor depending on how  
4 committed they were to the whole idea. Some  
5 people didn't use it at all. Some used for half  
6 of their prescriptions. It never really rose to  
7 the level of clinical acceptance. If you're going  
8 to run an electronic system and you're going to  
9 store records and you're going to have  
10 information, you pretty much have to -- everybody  
11 has to use it all the time. Same is true with  
12 electronic medical records. You can't opt in and  
13 opt out or you get these gaping holes in your  
14 database.

15 So we never got even close to what  
16 I -- what I would call acceptable utilization  
17 rates.

18 Q. Okay. Do you -- do you remember  
19 offhand whether the doctor that was the OB-GYN was  
20 the doctor that never used it at all versus used  
21 it half the time?

22 A. My memory is foggy here, but my --  
23 my best estimate would be that if we included him,  
24 he didn't use it.

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1 Q. On the Santa Barbara Clinic, do you  
2 know whether or not -- let me back up.  
3 With the Santa Barbara Clinic, is  
4 that a similar experience in terms of some doctors  
5 using half the time, some not at all?

6 A. Yes. These systems are real touchy  
7 and, you know, not only does it take more time to  
8 order a script than to write one, but electronic  
9 systems don't always work. So it was -- if you  
10 didn't have a physician who was really committed  
11 to this, the aggravation that resulted from it  
12 would turn them off.

13 Q. Okay. Omni Health Care. We can  
14 jump over there for a minute. You were the vice  
15 president, medical affairs, and chief medical  
16 officer from May of 1996 through January of 1998;  
17 correct?

18 A. I don't know the month, but it would  
19 have been '96 to '98. It would have been a couple  
20 of years.

21 MR. DOBIE: Let us just mark this as  
22 the next exhibit.

23 \* \* \*

24 (Whereupon, Gibson Exhibit 4 was

1 marked for identification.)

2 \* \* \*

3 BY MR. DOBIE:

4 Q. I hand you what we marked as Exhibit

5 4. Dr. Gibson, do you recognize Exhibit 4?

6 A. Do I -- I'm sorry?

7 Q. Do you recognize Exhibit 4?

8 A. Yes.

9 Q. This is -- this is the report that  
10 you prepared in the Duramed versus Wyeth case?

11 A. I would -- I believe that's  
12 accurate.

13 Q. Okay. In the -- in your CV that's  
14 attached thereto, you've got the time period Omni  
15 Health Care as May of '96 to June of '98. Does  
16 that refresh your recollection that that was the  
17 time?

18 A. It helps, yes. Thank you.

19 Are we done with this?

20 Q. Not quite. Not quite.

21 In this resume, you state, and this  
22 is on Page 14 -- we're talking about Omni. You  
23 state that "As the VP, medical affairs, I also  
24 chaired the pharmacy and therapeutics committee

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1 for the health plan." Do you see that? The very  
2 last line.

3 A. I see that.

4 Q. Okay. Now, in your -- your current  
5 resume that we've attached to -- or you've  
6 attached to your report at Exhibit 1, you have a  
7 description of Omni Health Care and you've deleted  
8 that sentence as having been the head of the P&T  
9 committee at Omni Health Care. I'm wondering why  
10 that -- why was that sentence deleted.

11 A. It was an inadvertent editorial.

12 Q. In which way?

13 A. It didn't have any -- it didn't have  
14 any bearing to experience or change. It's just  
15 what I included as my responsibilities.

16 Q. Okay. And so as it relates to --  
17 the resume that's attached to your current report,  
18 that's the accurate situation?

19 A. I chaired --

20 MR. COHEN: Objection to the form.

21 A. -- the committee.

22 BY MR. DOBIE:

23 Q. Oh, you did chair the committee?

24 A. I did chair the committee. I

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1 just -- I didn't happen to write it in this  
2 report.

3 Q. Oh, I see.

4 A. Or in this CV. I did a lot of  
5 things and you just pick and select what you put  
6 in it. This CV that you have here is generally  
7 used when I'm involved in a consulting engagement  
8 and --

9 Q. Which one for the record?

10 A. The one that is in the current  
11 report. And to chair a P&T committee for a lay  
12 reader, it doesn't have a lot of meaning for most  
13 people. It does within this context, but it  
14 wouldn't, say, with the owner of a business who  
15 wanted to engage Illumination Medical.

16 Q. Well, sir, you picked the resume to  
17 attach to your report; correct?

18 A. Correct.

19 Q. Okay. And did you think it was  
20 relevant whether you did or didn't serve as the  
21 chairman of the P&T committee at Omni Health Care?

22 MR. COHEN: Objection.

23 Argumentative.

24 A. I think it's relevant. If I were to

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1 redo it, I would have included it. I did,  
2 however, include it at the front of the report  
3 that I chaired it.

4 BY MR. DOBIE:

5 Q. Actually, your report says that you  
6 have been the CEO of three different HMOs. That's  
7 on Page 5 on your background. And looking through  
8 the resume, and I tried to add them up and count  
9 them up, I didn't come up with you being the CEO  
10 of three different HMOs.

11 What are the three different HMOs  
12 that you were the CEO of?

13 A. I was the CEO of the Sisters of  
14 Charity Health Plan in Houston. I was the CEO of  
15 the Tallahassee Physicians Association Health Plan  
16 in Tallahassee, Florida.

17 Q. I'm sorry. The Sisters of  
18 Charity --

19 A. In Houston.

20 Q. In Houston. And then what's the one  
21 in Tallahassee?

22 A. It would have been the Tallahassee  
23 Physicians Association Health Plan.

24 Q. Okay.

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1 A. And I was the CEO of the Samaritan  
2 Health Plan in Phoenix.

3 Q. When were you the -- let's look at  
4 your -- your report here. Maybe you've got the  
5 dates.

6 A. Could we go back to one item? You  
7 had a question about whether or not --

8 Q. Yes, sir.

9 A. This issue of the P&T committee.  
10 If you'll look on Page 5 under the  
11 heading "Background," first paragraph, you'll see  
12 the last sentence --

13 Q. Oh, I see it.

14 A. Okay?

15 Q. When were you -- when were you the  
16 CEO of the Sisters of Charity Health Plan?

17 A. That was when I was at the -- these  
18 were all activities involved with my ownership of  
19 Avanti Health Plan. Avanti -- or not Avanti --  
20 Avanti Health Systems. Avanti was a medical  
21 development company and we developed all of those  
22 health plans from scratch, moved them through to  
23 licensure. I functioned as the CEO of the health  
24 plan during its startup and we would ultimately

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1 replace ourselves with recruited full-time staff.

2 Q. So where it says here Avanti Health  
3 Health Systems, says 1984 through 1991, your --  
4 your service as the CEO of the Sisters of Charity  
5 Health Plan in Houston would have been at what  
6 time period between 1984 and 1991?

7 A. That would have been early, so it  
8 would have been roughly '84, '85. It was -- our  
9 first client -- our first client in Texas was the  
10 Baylor Health System, and my partner, whose name  
11 is -- was Marty Dale, is -- his name, Marty Dale,  
12 was responsible for that project and he served as  
13 the CEO of the Baylor Health Plan in Dallas. And  
14 our second client was the Sisters of Charity in  
15 Houston and I took responsibility for that  
16 account.

17 Q. Okay. And -- and tell me more about  
18 what the Sisters of Charity Health Plan -- what  
19 that was.

20 A. It was a Catholic health system  
21 consisting of a number of hospitals distributed  
22 around the United States but most of them in  
23 Texas. The primary area was Houston. But they  
24 stretched over to Beaumont, down to San Antonio,

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1 and as I recall, there was one or two hospitals up  
 2 in northern Texas around the panhandle.  
 3 Q. Okay. But the Catholic health  
 4 system hospitals, I mean, that's been around  
 5 forever. What -- tell me, explain for me what you  
 6 did in terms of the creation of the Sisters of  
 7 Charity Health Plan as it -- and how that fits  
 8 within the Catholic health system.  
 9 A. Okay. We're going to get into a  
 10 little lesson here about Catholics.  
 11 Q. I've got plenty of them at home.  
 12 A. The Catholic hospitals in the United  
 13 States are not one entity. They are owned and  
 14 managed by various orders of sisters. The Sisters  
 15 of Charity -- their full name was the Sisters of  
 16 Charity of the Incarnate Word. Their -- their  
 17 base was in Houston. And they started their first  
 18 hospital, as most Catholics did, during the great  
 19 flu epidemic of -- I think it was 1912 and people  
 20 were dying like crazy, and basically they created  
 21 a place for people to die with dignity. And from  
 22 that they grew into a multibillion dollar  
 23 corporation and had hospitals distributed around.  
 24 When the HMO movement came into

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1 health care, you will recall that prior to, oh,  
 2 1980, back during the Nixon years, the majority of  
 3 health care was paid for by indemnity health  
 4 insurance, where you would see a physician or a  
 5 hospital, you would pay for the service, and then  
 6 you would be reimbursed by the insurance company  
 7 after you had met a deductible.  
 8 We -- there was a massive move in  
 9 the market to first dollar coverage or these  
 10 health plans at about that time, and the Sisters  
 11 of Charity, like many other hospitals, were  
 12 interested in forming their own insurance company.  
 13 So it would be essentially an inhouse underwriter  
 14 of their services.  
 15 This came out of people admiring  
 16 Kaiser and the concept was a three-legged stool,  
 17 wherein Kaiser had their own hospitals, their own  
 18 medical group, and their insurance company, and  
 19 many of the larger hospital systems in the America  
 20 were experimenting with that model. And we were  
 21 one of the major developers that could come in and  
 22 develop that for them.  
 23 Q. I mean, what your resume says is  
 24 that you were a development and management firm,

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1 Avanti Health Systems.  
 2 A. That's right.  
 3 Q. Okay. It's kind of a very broad  
 4 description. I'm just -- I'm trying to understand  
 5 when you talk about helping them and now you  
 6 mention Kaiser -- you know, did they -- did you  
 7 end up setting up a Kaiser-type shop for the  
 8 Sisters of Charity Health Plan?  
 9 A. I mentioned Kaiser in the context of  
 10 this three-legged stool concept and hospitals and  
 11 their physicians were exploring a Kaiser-like  
 12 entity that could compete in the prepaid market.  
 13 Q. All right. And is that what the  
 14 Sisters of Charity Health Plan was?  
 15 A. It was the -- one of the legs of the  
 16 stool.  
 17 Q. All right. Explain that for us, if  
 18 you will.  
 19 A. We were the insurance company.  
 20 Q. All right. So you developed an  
 21 insurance company for the Sisters of Charity?  
 22 A. Correct.  
 23 Q. For this particular hospital in  
 24 Houston?

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1 A. No. For their system.  
 2 Q. Systemwide?  
 3 A. Right.  
 4 Q. And then you did the same thing for  
 5 the Tallahassee Physicians Health Plan?  
 6 A. That was -- that was -- yes, that  
 7 was formed by the physicians in Tallahassee that  
 8 were in independent practice and they contracted  
 9 with us to form a health plan, which we were able  
 10 to take through development to licensure by the  
 11 state and ultimately federal licensure.  
 12 Q. And so each of these is -- and then  
 13 the Samaritan Health Plan in --  
 14 A. Phoenix.  
 15 Q. In Phoenix. Same thing. You're  
 16 basically creating a health plan?  
 17 A. Correct.  
 18 Q. All right. And these are just like  
 19 if -- if you have a company with 10,000 people.  
 20 You're describing four. They may create a health  
 21 plan. They might have consultants that advise  
 22 them in connection with the creation of a  
 23 particular health plan. You mentioned before the  
 24 ERISA plans, the Taft-Hartley-type structures,

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1 those are the types of health plans that you're --  
2 that you -- that you created when you were at  
3 Avanti Health Systems?  
4 A. No.  
5 Q. All right. Explain that for me.  
6 A. The products that we developed at  
7 Omni would be --  
8 Q. Omni or Avanti?  
9 A. Avanti. Sorry.  
10 Were two types. One was an HMO  
11 which was licensed by the state and federal  
12 licensure. And it was a -- it -- it delivered  
13 first -- first dollar products that would be HMO  
14 products.  
15 The second type of an insurance  
16 company we would create in tandem with that was an  
17 indemnity insurance company that would stand  
18 behind PPO products. That would be -- stands for  
19 preferred provider organizations.  
20 Q. Okay. And the Sisters of Charity  
21 Health Plan, as you mentioned before, was an  
22 insurance company?  
23 A. The Sisters of Charity -- we formed  
24 two companies for them. One was the Sisters of

1 A. I'd say around six months.  
2 Q. And --  
3 A. Maybe a little longer for the last.  
4 It could have been 12 months.  
5 Q. Okay. And with each of those three  
6 plans, was -- was the pharmacy benefit carved out?  
7 A. The pharmacy benefit for the most  
8 part really didn't exist in -- in its current  
9 iteration until the early portion of 1990.  
10 Q. So is the answer yes, the pharmacy  
11 benefit was carved out?  
12 A. Well, the pharmacy benefit was for  
13 the most part a discount card.  
14 Q. Okay.  
15 A. So that -- that doesn't technically  
16 fit the term "carved out." It was an add-on  
17 supplement that the purchaser could buy, but for  
18 the most part they were not insurance products.  
19 They were in many ways quite similar to what is  
20 coming out of Medicare now.  
21 Q. Okay. And I've asked you some other  
22 questions about Avanti that I don't believe I need  
23 to repeat.  
24 You said you read your deposition on

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1 Charity Health Plan and the other was the Sisters  
2 of Charity Indemnity Insurance Company, I believe.  
3 Q. Okay. So you're -- you're helping  
4 them form this company. It -- after forming it,  
5 did you play a role in connection with the  
6 management of it?  
7 A. We did.  
8 Q. For how long?  
9 A. We developed the company and my  
10 staff staffed the company until we recruited and  
11 handed over to full-time -- full-time employees of  
12 the health plan. So I would serve as the CEO. My  
13 director of marketing served as the director of  
14 marketing. My network developer would develop the  
15 physician networks.  
16 Q. All right. And for how long did you  
17 serve as the CEO of the Sisters of Charity Health  
18 Plan?  
19 A. For about a year.  
20 Q. How long did you serve as the CEO of  
21 the Tallahassee Physicians Health Plan?  
22 A. About six months.  
23 Q. And how long did you serve as the  
24 CEO of the Samaritan Health Plan in Phoenix?

1 the way out. Was there anything in that  
2 deposition that you felt the need to correct?  
3 A. I read -- I just glanced over it on  
4 the plane coming out here. In general, I think  
5 it's fine. I'm sure there will be minor things  
6 that we'll go over as we spend the day, but  
7 nothing --  
8 Q. Was that the first time you read it?  
9 A. I read it one other time after I --  
10 you and I visited in Sacramento, because I had to  
11 sign the deposition. But those are the two times  
12 I've read it.  
13 Q. Right. And when you signed it, you  
14 didn't have any -- any corrections to the  
15 substance?  
16 A. I wouldn't have signed it if I did.  
17 Q. Okay.  
18 MR. COHEN: Gordon, are we at a time  
19 to take a little break?  
20 MR. DOBIE: Sure. It's been a  
21 couple hours.  
22 THE WITNESS: Sounds good to me.  
23 THE VIDEOGRAPHER: This is the end  
24 of Tape No. 1. The time is 12:02 p.m.

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1 We're now off the record.

2 \* \* \*

3 (Whereupon, a short recess was

4 taken.)

5 \* \* \*

6 THE VIDEOGRAPHER: This is the

7 beginning of Tape No. 2. The time is 12:20.

8 We're back on the record.

9 BY MR. DOBIE:

10 Q. Dr. Gibson, I want to ask you a

11 little bit more about your -- your resume that you

12 attached to your report.

13 You mentioned in here some of your

14 certifications. Are you a member of any

15 professional associations?

16 A. I'm a member of the California

17 Medical Association.

18 Q. Anything else?

19 A. Not now.

20 Q. Have you ever been a member of

21 the -- have you ever been a member of the American

22 Pharmaceutical Association?

23 A. No.

24 Q. Have you ever been a member of the

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1 California Pharmaceutical Association?

2 A. I'm not a member. I -- if you'll

3 recall, the California Pharmaceutical Association

4 owns PCN, and I work very closely with the

5 California Pharmacists Association primarily as a

6 consultant.

7 Q. Right. But are you a member of the

8 California --

9 A. No.

10 Q. -- Pharmaceutical Association?

11 Are you a member of the American

12 Managed Care Pharmacy Association?

13 A. No.

14 Q. Are you a member of the National

15 Association of Chain Drugstores?

16 A. No.

17 Q. Are you a member of the National

18 Council of Prescription Drug Programs?

19 A. No.

20 Q. Are you a member of the pharmacy

21 advisory committee for the California Medi-Cal?

22 A. No.

23 Q. Do you serve on any advisory panels

24 with any pharmaceutical manufacturers?

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1 A. No.

2 Q. Do you serve on any industry

3 advisory panels with any -- or for any PBMs?

4 A. No.

5 Q. Publications are listed in

6 Attachment B to your bibliography, the last 10

7 years. It looks like the last article that you

8 wrote involved fraud in health care, and this is

9 an article that discusses how fraud is a serious

10 problem that physicians are involved in in health

11 care in California; correct?

12 A. Well, the article discusses the

13 issue of fraud in health care, and physicians

14 being part of the system, it discusses that, yes.

15 Q. Okay.

16 A. It didn't base its discussion that

17 physicians were the cause of fraud particularly.

18 Q. No. But the focus of the article is

19 physician fraud; correct?

20 A. No. The focus of the article was

21 fraud in health care.

22 \* \* \*

23 (Whereupon, Gibson Exhibit 5 was

24 marked for identification.)

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1 \* \* \*

2 BY MR. DOBIE:

3 Q. I show you what we marked as Exhibit

4 5. Sir, for the record, Exhibit 5 is a copy of

5 the article that we're just discussing, "Fraud in

6 Health Care," that you published in February of

7 '04; correct?

8 A. Correct.

9 Q. And this is -- the Sierra Sacramento

10 Valley Medical Society has a newsletter that

11 you -- you edit; correct?

12 A. It's not a newsletter. It's a --

13 it's a newspaper --

14 Q. Okay.

15 A. -- or a magazine.

16 Q. A magazine?

17 A. A better way to put it. It's a

18 magazine. And I serve on the editorial committee

19 and I'm the associate editor of the magazine.

20 Q. And are any of the -- any of the

21 articles -- let's start with this one. This is

22 not a peer-reviewed article; correct?

23 A. Correct.

24 Q. And are any of the articles that are

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1 on your CV peer-reviewed articles?

2 A. No, these are not peer-reviewed

3 articles.

4 Q. Have you ever published anything

5 that's been peer reviewed?

6 A. Many times, but it was earlier than

7 10 years ago. It would have been back when I was

8 in academic positions at Harvard.

9 Q. All right. And the -- what are some

10 of the subjects that you've published on --

11 A. My area --

12 Q. Let me finish. -- as it relates to

13 peer-reviewed articles?

14 A. Most of them dealt with the area of

15 immunogenetics. I was particularly interested in

16 the genetic background of children who got

17 arthritis, so I published in that area. I did HLA

18 tissue typing.

19 Q. All right. And the -- have you ever

20 published any peer-reviewed article in the -- in

21 any -- have you ever published a peer-reviewed

22 article that relates to managed care issues?

23 A. No, I have not and I've -- in

24 general, those types of articles aren't peer

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1 reviewed.

2 Q. And what are the -- what are the

3 publications that you're familiar with that

4 address managed care issues?

5 A. Oh, there are hundreds. It's

6 approached either from the insurance industry

7 perspective or from the pharmaceutical industry

8 perspective or the medical physician perspective

9 or the employer perspective.

10 Q. Okay. You said that most articles

11 on managed care are not peer reviewed.

12 Have you seen, for example, articles

13 that discuss topics like the impact of copays on

14 prescribing habits and things like that?

15 A. Generally those types of articles

16 are not peer reviewed. They -- they fall more

17 into the category of what you have in front of

18 you, which would be -- probably the best category

19 would be op-ed type pieces or editorials, or they

20 could include data, but they're not -- they're

21 not -- they -- they'd all fall into the -- when

22 I -- when I would publish for the New England

23 Journal of Medicine, say, that was heavily peer

24 reviewed by six or seven authorities in the field

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1 before it would be published in the New England

2 Journal of Medicine.

3 Q. Okay. So just answer my question

4 then. You have not published any peer-reviewed

5 article that relates to managed care issues;

6 correct?

7 A. Correct.

8 Q. All right. We discussed in your

9 last deposition your prior service as an expert

10 witness in litigation. I think you told me

11 that --

12 A. Are we done with this?

13 Q. Yes, sir. -- that the -- that the

14 Duramed case was the first lawsuit that you'd --

15 that you'd been involved in; is that correct?

16 A. Correct.

17 Q. Have you been involved in any other

18 litigation since the Duramed case?

19 A. The only other -- there -- there

20 were two instances, which really weren't

21 litigation. They could have been.

22 One was I was rear-ended on

23 Interstate 80 and had a retired judge help me

24 settle the case with the insurance company. That

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1 was a matter of correspondence.

2 And the other was my daughter was

3 involved in a rear-end collision and our insurance

4 company worked with that.

5 Q. But in terms of you working as an

6 expert in any litigation --

7 A. Oh, no.

8 Q. No. And your report indicates that

9 you're being paid \$300 per hour for research time

10 and \$500 an hour for testimony.

11 A. That's correct.

12 Q. And in the Duramed case, you were

13 paid \$300 an hour. Why the difference in your

14 rates?

15 A. I've gotten better.

16 Q. All right. How have you gotten

17 better?

18 A. I have more experience. You taught

19 me a lot in the last round.

20 Q. All right. Did -- did you, sir -- I

21 guess, why are you making the distinction between

22 time that you're spending on testimony versus time

23 that you're spending on research?

24 A. This is more difficult.

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1 Q. Have you ever commanded \$500 an hour  
2 before for any of the other projects that you've  
3 done?

4 A. My -- my fees in consulting  
5 generally run between 3 and 5 hundred dollars an  
6 hour.

7 Q. And what company --

8 A. Plus expenses.

9 Q. What company -- which of your  
10 companies have you charged clients 3 or 5 hundred  
11 dollars an hour for?

12 A. Well, we discussed UPNI earlier.  
13 I'm charging them 300 an hour.

14 Q. Who have you charged 500 an hour to?

15 A. The charges for that range would  
16 usually fall in the arena of retained fees or  
17 deliverables. So I'm not billing by the hour, but  
18 it works out to that.

19 Q. What -- what do you mean by  
20 "retained fees" or --

21 A. Well, for instance, Illumination  
22 Medical charges on a per employee per month basis,  
23 and those are based on deliverables. So we  
24 deliver a report quarterly to the client and they

1 solid.

2 Q. But about 120 hours or so?

3 A. I'd say more than that. I would  
4 work -- when I -- when I'm billing, I work longer  
5 than an eight-hour day usually.

6 Q. That's why I gave you the 120.

7 A. Yes.

8 Q. What's the --

9 A. I'd say I'm more closer to 200  
10 hours.

11 Q. 200 hours? So how much have you  
12 been paid so far in connection with this  
13 engagement?

14 A. Again, I don't have the records with  
15 me, but I'd say probably around \$60,000 or so.

16 Q. So are you still owed \$40,000 as  
17 you're sitting here today?

18 A. No. Mr. Cohen has been very good  
19 about reimbursing my invoices.

20 Q. Okay. Well -- all right. So  
21 it's -- I see. \$300 an hour times the 200 hours  
22 is 60. Got it.

23 Okay. When were you retained to  
24 work on this J.B.D.L. case?

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1 pay monthly based on a per employee basis. So  
2 depending on how long it takes me to generate a  
3 report to the client is not based on hourly but  
4 the deliverable.

5 Q. Okay. Is anybody -- can you name  
6 any other company that's actually agreed to pay  
7 you \$500 an hour?

8 A. No.

9 Q. Do you maintain time records that  
10 you spend in connection with this engagement?

11 A. I do.

12 Q. And how do you keep your time?  
13 What's -- what's your process in connection with  
14 this engagement?

15 A. I usually log in each day how much  
16 time I spend or if I spend nothing in a day, I  
17 don't log anything in. Keep it on an Excel  
18 spreadsheet and turn in a invoice every couple of  
19 weeks.

20 Q. And how much time have you spent in  
21 connection with your engagement in this case?

22 A. I'd say -- I don't have the records  
23 with me, but I'd say I've roughly spent about  
24 three weeks in aggregate. That's not three weeks

1 A. Let's see. As I recall, it was the  
2 latter part of last year.

3 Q. So late 2003?

4 A. Yes. I recall that Mr. Cohen  
5 contacted me and we met in Sacramento, and as I  
6 recall, it was latter part of 2 --204 -- 203.

7 Q. Okay. And what did Mr. Cohen tell  
8 you about the case when you met with him?

9 A. First he called and gave me a very  
10 high-level look that -- as to who the plaintiffs  
11 and the defendants were and roughly what the case  
12 was about and then asked if I'd be interested, and  
13 I said I would be interested in working on the  
14 case. And we scheduled an opportunity to have  
15 lunch together in Sacramento and we walked around  
16 the grounds of the capitol and visited and talked  
17 about it.

18 Q. What did he -- what did he -- tell  
19 me what he said about his case, about the case  
20 that was on file.

21 A. He said that this was a suit between  
22 your client, Wyeth, as the defendant, and a class  
23 of -- of individuals or businesses that consisted  
24 mostly of the -- of most of the distribution

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1 chain -- chains, the distribution system within  
2 the pharmaceutical industry in the United States.  
3 That would include most of the wholesalers and  
4 most of the retailers with the exception of Rite  
5 Aid and CVS.

6 Q. All right. And what did you -- when  
7 he described the case, what did you say in  
8 response?

9 A. I said that it looked interesting  
10 and that I would be interested in working with him  
11 as an expert witness on it.

12 Q. Now, did you -- did you have some  
13 understanding as to what area you were going to be  
14 asked to be an expert in?

15 A. I did.

16 Q. And what was your understanding of  
17 what area you were going to be asked to be an  
18 expert in?

19 A. My responsibility was to be able to  
20 describe and explain how the health care system  
21 works, how it works in its broad perspective,  
22 including both the medical and the pharmaceutical  
23 distribution systems, how their -- how money flows  
24 through those systems, and how those systems can

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1 and were influenced.

2 Q. Go back and look at what we marked  
3 today as -- as Gibson Exhibit 4, if you would,  
4 sir.

5 A. Me?

6 Q. Yes, sir. You got your report as 1.  
7 And there's your report there.

8 A. Okay.

9 Q. All right. And on the second page  
10 of this report, you state that you were asked to  
11 prepare a report in order to provide an expert's  
12 perspective on how restrictions of formulary  
13 listings by major managed care organizations  
14 affect the prescribing behavior of physicians.  
15 "Specifically I will analyze the consequences of  
16 Cenestin being excluded from substantially all  
17 major managed care formularies from Cenestin's  
18 market introduction in 1999 to the present." Do  
19 you see that? Right at the top.

20 A. Yes. Okay. Yes, I do see that.

21 Q. All right. And in your current  
22 report, you state that you are now going to give  
23 an expert opinion that extends -- this is on Page  
24 6 of your current report. In your current report

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1 on Page 6, you have a broader description of what  
2 you've been asked to do. You state that you were  
3 asked to prepare a report in order to provide an  
4 expert perspective on how Wyeth accomplished its  
5 anticompetitive objective using exclusive dealing  
6 and market share incentive-based contracts within  
7 the health care systems. You were going to  
8 analyze the cumulative effect of this successful  
9 marketing strategy and how it influenced the  
10 decision making by American physicians as they  
11 selected estrogen products in their patient and  
12 that your report will analyze the consequences of  
13 Cenestin being excluded as a result of Wyeth  
14 successfully executing marketing strategy from  
15 substantially all major managed care formularies  
16 for Cenestin's market introduction in 1999 to the  
17 present. Do you see that?

18 A. Yes.

19 Q. Why the broader scope of this  
20 report?

21 A. This was what I was asked to -- to  
22 evaluate and report on.

23 Q. Weren't you asked to do the same  
24 thing in the Duramed case and you suggested that

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1 Mr. Susman would be better served by having Mr.  
2 Bystrom play that role?

3 MR. COHEN: Object to the form.

4 A. I -- with -- on the Susman case, I  
5 did recommend that the Susman firm bring in Mr.  
6 Bystrom to comment on and report on the dispensing  
7 side of the aisle and I kept the prescribing side.

8 \* \* \*

9 (Whereupon, Gibson Exhibit 6 was  
10 marked for identification.)

11 \* \* \*

12 BY MR. DOBIE:

13 Q. Let me show you what's been marked  
14 as Bystrom Exhibit 6. I'm sorry, Gibson Exhibit  
15 6. For the record, Exhibit 6 is a copy of the  
16 Bystrom deposition that was taken on July 18th,  
17 2002.

18 This is something that you reviewed  
19 before your last deposition; correct?

20 A. As I remember, I did read it.

21 Q. All right. And -- and if you turn  
22 to Page 218 of that deposition. It's towards the  
23 back.

24 A. Okay.

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1 Q. You were asked a series of  
2 questions --  
3 A. I was?  
4 Q. Yes, sir. I'm sorry. Mr.  
5 Bystrom --  
6 A. Bystrom.  
7 Q. -- was asked a series of questions  
8 about his retention in this matter, and he was  
9 asked, "Did you and Mr. Gibson discuss your  
10 reports -- or Dr. Gibson discuss your reports with  
11 each other before they were submitted?"  
12 "ANSWER: We knew that we were both  
13 working on reports and that his was focused on the  
14 physician area and mine was focused on pharmacy  
15 and PBM."  
16 Next question: "Did you have  
17 conversations with Dr. Gibson about the substance  
18 of your report?"  
19 "ANSWER: No, not necessarily.  
20 "QUESTION: What sort of  
21 conversations did you have with Dr. Gibson about  
22 your report?"  
23 "ANSWER: We talked about the fact  
24 that originally he was the first person contacted

1 asked him to do that. My question is different.  
2 Did you say to him that it was not  
3 your area of expertise, that being pharmacy and  
4 PBM information?  
5 A. Again, I was -- I was aware of  
6 rebates and how they worked. I did not feel that  
7 my area of expertise was as deep as his at that  
8 time and I felt it served the Susman firm better  
9 if they brought him in.  
10 Q. And what do you mean by your area of  
11 knowledge wasn't as deep as his?  
12 A. Well, Dale had started -- Mr.  
13 Bystrom had started a PBM himself. He started  
14 Longs Drugstores PBM that ultimately became  
15 RxAmerica. So he had many years of experience in  
16 the PBM industry, how -- how -- the minutiae of  
17 how things worked, and he had years of experience  
18 in the retail pharmacy. So he had worked with the  
19 information systems within the pharmacies and so  
20 forth, which I had not done.  
21 Q. Given that, sir, why did you not  
22 also recommend Mr. Bystrom as an expert in this  
23 case?  
24 A. I didn't -- I didn't have a say as

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1 by Duramed through Susman to create a report that  
2 was inclusive of pharmacy and PBM information; and  
3 then he quickly realized that that's not where his  
4 expertise was and recommended they contact me for  
5 that. So then I told him that I would be working  
6 in that area, and those are the expert opinions  
7 that were rendered based on the things in those  
8 two weeks" and so on.  
9 First let me ask you. Is -- is Mr.  
10 Bystrom correctly describing his conversation with  
11 you back in this time period?  
12 A. He's pretty -- pretty accurate.  
13 There were -- there -- there's some additions to  
14 that that could be made.  
15 Q. Is it -- is it a true statement that  
16 you said to him that your area of expertise was  
17 not on the pharmacy and PBM side?  
18 A. At that time, my statement to him  
19 was that I wanted him involved in the case to  
20 buttress that.  
21 Q. Okay.  
22 A. So it could -- it comes out this  
23 way.  
24 Q. All right. I understand that you

1 to who would be the consultants or the experts on  
2 this case, so I can only speculate on why Mr.  
3 Bystrom was not asked. My level of experience  
4 within the PBM environment and how the pharmacies  
5 actually work operationally changed considerably  
6 from this time to the present.  
7 Q. All right. What do you mean that  
8 you didn't have a say? Did you recommend to Mr.  
9 Cohen or any of the other lawyers that they would  
10 be better served to have Mr. Bystrom as an  
11 additional expert in this case?  
12 A. I asked Mr. Cohen if he was going to  
13 retain Mr. Bystrom and he said no.  
14 Q. Did he say why not?  
15 A. No. He indicated that he wanted me  
16 to cover these areas, and I left it at that. And  
17 I left it at that because I felt confident that I  
18 could do this job for him.  
19 Q. We'll come back in a -- in a bit to  
20 your additional expertise and experience, but I  
21 want to go through some more questions as it  
22 relates to your retention before we get back to  
23 that.  
24 A. Are we done with this?

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1 Q. For the moment. It will -- it will  
2 be another -- you can put it in the stack there.  
3 What materials have you reviewed to  
4 prepare to testify and provide a report in this  
5 case?  
6 A. Well, certainly everything that was  
7 footnoted in my report was reviewed. I believe  
8 that Mr. Cohen delivered to you a list of articles  
9 that -- or not articles, but discovered documents  
10 that I had been given during the course of my  
11 evaluation, and then my general ongoing reading in  
12 both the lay and professional press.  
13 \* \* \*  
14 (Whereupon, Gibson Exhibit 7 was  
15 marked for identification.)  
16 \* \* \*  
17 BY MR. DOBIE:  
18 Q. Okay. For the record, Exhibit 7 is  
19 a copy of the document that you were just  
20 referring to, which is the e-mail from Mr. Cohen  
21 that describes additional materials that you  
22 reviewed.  
23 And for the record, sir, are  
24 these -- does this list that's included in Exhibit

1 In addition, it does not include any  
2 of the documents that Dr. Gibson reviewed as  
3 part of his charge in the Duramed case.  
4 And, of course, all the documents he  
5 reviewed in the Duramed case are also  
6 documents that are part of the current case.  
7 So he brought that knowledge with him into  
8 the case.  
9 So I apologize for interrupting  
10 your -- your line of questioning, but I just  
11 wanted to clarify that.  
12 MR. DOBIE: Okay. That's -- that's  
13 perfectly fair and actually helpful.  
14 THE WITNESS: Could I say just one  
15 other thing too on that?  
16 BY MR. DOBIE:  
17 Q. Yes.  
18 A. And that is after the Duramed case I  
19 kept no documents. So I didn't keep a box or  
20 several boxes --  
21 BY MR. DOBIE:  
22 Q. So you -- you destroyed all the  
23 documents that you --  
24 A. I sent them back to Susman.

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1 7, the third or fourth pages, together with the  
2 documents that are cited in your report, together  
3 with -- I think you said materials that were in  
4 the lay or professional press constitute the  
5 universe of information that you reviewed in  
6 issuing your -- preparing your report?  
7 A. I would -- I would say so. This --  
8 these last two pages are a series of -- what's the  
9 term that you have --  
10 Q. Bates numbers?  
11 A. Yes. So I'm not sure that, you  
12 know, for instance I saw WYE117064. I probably  
13 did. But this looks about right. I had several  
14 boxes of discovered documents.  
15 Q. Okay.  
16 MR. COHEN: I'm sorry to interrupt  
17 you, but just so the record is clear, and  
18 since this is my e-mail, Mrs. Ward asked --  
19 Mrs. Ward asked me for this listing, and  
20 because of time factors, it's not -- it's  
21 not intended to be an all-inclusive list.  
22 So, in other words, it may be duplicative of  
23 what's cited and it may be on top of what's  
24 cited.

1 Q. Okay. And so -- so you could --  
2 whatever you could recall of the documents from  
3 the Duramed case, I guess that would form in part  
4 maybe some of your knowledge base that you're  
5 telling us about here today and that's in your  
6 report; correct?  
7 A. Yes. I requested that the documents  
8 cited in my report and many of the documents cited  
9 in Dale -- Dale Bystrom's report be sent to me for  
10 review.  
11 Q. Okay. So -- so you received those  
12 documents from counsel?  
13 A. I did.  
14 Q. All right. And then -- and then how  
15 did you go about selecting or deciding what else  
16 to look at?  
17 A. I learned a great deal from the  
18 first round, and what I learned was the way to  
19 approach a complex subject like this is to start  
20 with your outline. So the first series of  
21 exchange of documents between me and Mr. Cohen  
22 dealt with creating the outline of what I was  
23 going to write about. So that went through  
24 several iterations. So I was focused on the

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1 subject that I needed to cover. For instance, I'm  
2 not involved in the economics of the case.  
3 There's another expert that will be dealing with  
4 that. Or the pricing per se of drugs. So there  
5 was a give-and-take between us on what the outline  
6 would look like.

7 Once we got to a pretty complete  
8 outline of what I was going to write about, then  
9 I'd ask for his assistance in helping me find  
10 documents that related to the issues I was going  
11 to review. So it was through that process that I  
12 got my first pass at the documents that I would  
13 review.

14 And then there was a -- there was a  
15 document that came to light. I don't recall  
16 exactly how it came to light. But it was the  
17 contracting manual of Wyeth. And that produced in  
18 my mind a whole series of questions that I wanted  
19 to get more detail on. And so that -- that  
20 produced an interest in documents for me.

21 So I think that -- that pretty well  
22 explains how I wound up with the documents that I  
23 did have and how I used them in writing my report.

24 Q. Okay. Can I -- can I just sum up

1 A. I think that he brought that to my  
2 attention. And then after reviewing that, I had a  
3 lot of questions.

4 Q. Okay. So the -- so the -- again to  
5 sum up, do I have it all then? You've got --

6 A. Yes, I think you've got --

7 Q. -- the documents --

8 A. I think you've got it all.

9 Q. All right. Just so the record is  
10 clear.

11 We've got the documents that were  
12 cited that you wanted to have additional copies  
13 from either your last report or Mr. Bystrom's  
14 report; the documents that were selected by Mr.  
15 Cohen for you to review as part of the preparation  
16 of the outline, which then makes its way into the  
17 final report; and then last, documents that --  
18 that you became interested in as a result of the  
19 contract resource manual being brought to your  
20 attention?

21 A. I think that sums it up, yes.

22 Q. All right. And the specific  
23 documents that you were interested in as a result  
24 of your review of the contract resource manual

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1 then and make sure I have it?

2 In essence, you -- you asked for and  
3 received the documents that were cited in your  
4 last report and in Mr. Bystrom's report?

5 A. Right. Some of them. I didn't ask  
6 for all of them, but I did select ones I wanted.

7 Q. Okay. Second, you -- you had  
8 documents that were selected by Mr. Cohen as being  
9 helpful to whatever you guys were thinking about  
10 putting into the report based upon the outline?

11 A. Correct.

12 Q. Okay. And then -- and then as you  
13 mentioned before, there are documents that you may  
14 have -- or articles that you might have seen in  
15 the press?

16 A. No. The third thing I cited was the  
17 issue of the -- Wyeth's contracting manual that  
18 was in 1995.

19 Q. Okay. But that's -- I'd put that  
20 within the group of documents that Mr. Cohen  
21 brought to your attention.

22 A. Oh. I think that's how I -- I  
23 wouldn't have known about it otherwise.

24 Q. Okay.

1 were what, sir?

2 A. I was particularly interested in  
3 how -- in examples of how the Wyeth personnel  
4 included the verbiage from the contracting manual  
5 in the actual consummated contracts on the market.

6 Q. Sir, if you look back at Exhibit 7.

7 A. Sorry. I --

8 Q. That's the e-mail from Mr. Cohen.

9 A. Oh, okay. Yes. Okay.

10 Q. Do you have that in front of you?

11 A. I've got it here.

12 Q. And if you look at the list of  
13 documents, you don't mention Mr. Bystrom's report  
14 as one of the things that you reviewed. Why is  
15 that?

16 MR. COHEN: And again, Gordon, sorry  
17 to interrupt, but Dr. Gibson didn't prepare  
18 this. I prepared this and that would be my  
19 omission, not Dr. Gibson's.

20 MR. DOBIE: All right.

21 BY MR. DOBIE:

22 Q. So did you review this before  
23 this -- this was sent to us?

24 A. I -- these were inventories that

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1 were -- accompanied the times when he sent me  
 2 reports. So no, I didn't actually see it before  
 3 it was sent off to you, but I recognize these as  
 4 the documents that accompanied the reports.  
 5 Q. Okay. So -- so the process was when  
 6 you got a -- you would get a series of documents  
 7 from Mr. Cohen. Would you get a transmittal  
 8 letter that said enclosed is --  
 9 A. Something like that, yes.  
 10 Q. With the Bates numbers?  
 11 A. Something like that or a covering  
 12 index of within this box you will find these  
 13 referenced document -- documents.  
 14 Q. All right. The -- and I see that  
 15 there is -- in your entire report, I didn't see  
 16 any documents that you cited that came from  
 17 Duramed.  
 18 Is there some reason why you didn't  
 19 cite any documents that came from Duramed?  
 20 A. In -- in my report that I turned in?  
 21 Q. Yes, sir.  
 22 A. I can't think of a particular reason  
 23 why I didn't.  
 24 Q. And the --

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1 A. This report ran for almost a hundred  
 2 pages, so --  
 3 Q. Right. In the material that you  
 4 reviewed, I only see five pages that referenced  
 5 documents that came from Duramed.  
 6 Again, Mr. Cohen didn't send you  
 7 any -- any additional documents that came from  
 8 Duramed, to your recollection?  
 9 A. Not to my recollection.  
 10 MR. COHEN: I'm sorry, Gordon. I'm  
 11 not sure that I understood what you just  
 12 said.  
 13 Did you just say that there were  
 14 five pages that referenced Duramed  
 15 documents?  
 16 MR. DOBIE: Yes.  
 17 MR. COHEN: Because there's only one  
 18 page that references any -- are you -- are  
 19 you saying that there's five Duramed cites?  
 20 Is that what you meant?  
 21 MR. DOBIE: Yes. If you look at --  
 22 MR. COHEN: Okay.  
 23 MR. DOBIE: You've got DUR35, DUR37,  
 24 again 36 --

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1 MR. COHEN: I understand. I just  
 2 misunderstood how -- how you were stating  
 3 it. I'm sorry.  
 4 MR. DOBIE: All right.  
 5 BY MR. DOBIE:  
 6 Q. And did you, sir, have the  
 7 opportunity to interview anybody from Duramed in  
 8 connection with the preparation of your report?  
 9 A. No, I didn't.  
 10 Q. Did you interview anybody from  
 11 Viking in connection with the preparation of your  
 12 report?  
 13 A. No, I did not.  
 14 Q. Did you review -- interview anybody  
 15 from Barr Labs in connection with the preparation  
 16 of your report?  
 17 A. No.  
 18 Q. Did you interview anybody from  
 19 Solvay in connection with the preparation of your  
 20 report?  
 21 A. No.  
 22 Q. Did you interview anybody from  
 23 Cardinal in connection with the preparation of  
 24 your report?

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1 A. No.  
 2 Q. I assume you haven't spoken with  
 3 anybody at Wyeth in connection with the  
 4 preparation of your report?  
 5 A. You can assume that, yes.  
 6 Q. Did you speak with any witness in  
 7 this case that has knowledge of the situation with  
 8 Premarin and Duramed and the Cenestin product in  
 9 connection with the preparation of your report?  
 10 A. Okay. Now, you're asking did I  
 11 visit with any witness that was involved in the  
 12 prior suit, not this one that we're here on?  
 13 Q. Yes, sir.  
 14 A. Well, I visited -- visited many  
 15 times with Dale Bystrom.  
 16 Q. Okay. Anybody else?  
 17 A. No.  
 18 Q. Did you interview with any of the  
 19 witnesses in the J.B.D.L. case?  
 20 A. No.  
 21 Q. Have you had any discussions with --  
 22 with a particular plaintiff in this case, the  
 23 J.B.D.L. Pharmacy?  
 24 A. No.

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1 Q. Have you had any discussions with  
2 anybody from the Q Pharmacy?  
3 A. No.  
4 Q. Have you been retained by the  
5 indirect purchasers class action as well?  
6 A. No. I'm not sure what that one is.  
7 Q. All right. So Mr. Cohen is the --  
8 in his group, which is the direct purchasers, the  
9 large wholesalers and retailers, they're the ones  
10 that have retained you in connection with this  
11 matter?  
12 A. Correct.  
13 MR. COHEN: And CVS and Rite Aid.  
14 MR. DOBIE: That was my next  
15 question.  
16 BY MR. DOBIE:  
17 Q. Have you -- have you been retained  
18 by CVS and Rite Aid?  
19 A. It's understanding that I have been.  
20 Q. Okay. When did that occur?  
21 A. I would have to defer on that. I  
22 don't know. I've been working with Mr. Cohen, and  
23 I understand that -- that Rite Aid and CVS is one  
24 of the parties -- or is sharing the cost involved

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1 in this case, but I -- until -- really until I  
2 came for this -- this deposition, I was not fully  
3 aware of that.  
4 Q. Had you met Mr. Einhorn before  
5 today?  
6 A. No, I had not.  
7 Q. And have you ever had any discussion  
8 with Mr. Einhorn or anybody else representing CVS  
9 or Rite Aid before today?  
10 A. No.  
11 Q. How much did you -- did you come in  
12 yesterday in connection with this -- with this  
13 deposition?  
14 A. I came in on Sunday night.  
15 Q. Sunday night. Did you meet with Mr.  
16 Cohen?  
17 A. I did.  
18 Q. And when did you first meet with him  
19 in connection with the preparation for the  
20 deposition?  
21 A. I met with him yesterday morning at  
22 9 o'clock.  
23 Q. And when did you finish your meeting  
24 with Mr. Cohen?

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1 A. Around 2:00 in the afternoon.  
2 Q. What did you talk about in that  
3 meeting?  
4 A. Mainly I went over our deposition --  
5 my report with him. I reviewed the components of  
6 it. We talked about what was likely to come up as  
7 that document was reviewed today. I think it was  
8 just a matter of -- of my being able to really  
9 focus on the document and go back to what the case  
10 was all about so I understood exactly what I was  
11 testifying -- how my testimony fit in here.  
12 Q. What did he say about how your  
13 testimony would fit in here?  
14 A. He reiterated what my responsibility  
15 was, my area of responsibility. He indicated that  
16 when I didn't know something, I should say I don't  
17 know it. He indicated that I didn't -- unless you  
18 wanted to talk about it, that I really wasn't  
19 responsible for discussing the broader economic  
20 pictures or the -- how drugs got priced.  
21 So it was more of a review of what I  
22 was responsible for, what I wasn't responsible  
23 for, and again he reiterated that I should try to  
24 be brief in my answers, which I'm not sure I'm

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1 doing very well with.  
2 Q. Is -- your report, you don't discuss  
3 how -- how either Premarin or Cenestin were  
4 priced; correct?  
5 A. I know generally how they were --  
6 and what they -- what they were on the market for,  
7 but I have no knowledge of what was -- what went  
8 on behind the scenes as to how the companies  
9 priced them.  
10 Q. You haven't reached any conclusions  
11 or opinions as it relates to what impact any of  
12 the activities or things that you talk about in  
13 this report would have on the price of either  
14 Premarin or Cenestin, have you?  
15 A. I do have opinion.  
16 Q. But it's not in your report, is it?  
17 A. No.  
18 Q. Right. And -- and do you intend to  
19 offer that opinion at trial if you haven't put it  
20 in your report?  
21 A. I suppose if you ask.  
22 Q. Did you -- is there some reason why  
23 you didn't put it in your report?  
24 A. Well, again, it was -- I think there

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1 are people that can speak to that with much more  
2 eloquence and experience than I have.  
3 Q. All right. You -- you also mention  
4 Mr. Cohen said there's certain areas that might  
5 get focused on today.  
6 What did he say in that regard?  
7 A. I can't recall. I think -- I think  
8 we discussed how the review of the contracts that  
9 I included would be a matter of discussion. I  
10 think that there was a -- there was a give-and-  
11 take on the documentation relating to time flow  
12 studies for physicians. I believe that we --  
13 let's see.  
14 I think we reviewed in general the  
15 evolution of managed care, which was covered in  
16 the report. We talked again a bit about drug  
17 formularies and copayment structures and so forth.  
18 In general, I think we went through  
19 the table of contents and looked at -- looked at  
20 the report and just kind of generally chit-chatted  
21 back and forth about what I've written and that --  
22 you know, that these were going to be issues for  
23 questions.  
24 Q. Who wrote your expert report, sir?

1 into two portions. And what you saw as the  
2 finished product was what Dale had and what you  
3 had as the finished product was mine. However, a  
4 lot of the actual text in Dale's was written by me  
5 and a lot of the text in mine was written by Dale.  
6 Q. And let me ask you this, sir: You  
7 mentioned that the -- where you had taken from Mr.  
8 Bystrom, you had footnoted that in -- in your  
9 expert report in this case.  
10 If you turn to Exhibit 1 in this  
11 case just as an example, your 12th page of your  
12 report, the page you have right in front of you --  
13 A. Yes. What page number?  
14 Q. Page 12. I think you had it right  
15 in front of you there. Okay.  
16 Didn't you essentially just simply  
17 cut and paste this from Mr. Bystrom's report and  
18 now put it into yours?  
19 A. I cut and pasted this from Mr.  
20 Schondelmeyer's slide preparation.  
21 Q. You're talking about the chart?  
22 A. Yes.  
23 Q. Okay. So the chart was cut and  
24 pasted from Schondelmeyer. How about the text

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1 A. I did.  
2 Q. Every word?  
3 A. I pulled some of the verbiage from  
4 Dale Bystrom's report and footnoted it  
5 accordingly.  
6 And I would like to make a bit of a  
7 comment about that.  
8 Dale Bystrom and I worked throughout  
9 most of the drafts of the Duramed documents as a  
10 team. We were in the same room, particularly down  
11 in Houston, at Susman's law firm, where we had  
12 access to all of the documents. And we would --  
13 we would routinely trade text. We would -- we  
14 would routinely trade portions of the text back  
15 and forth between -- between ourselves. It was  
16 fairly late in the preparation of the final drafts  
17 that we actually demarcated where my report would  
18 end and his would begin.  
19 Q. Sir, I'm a little confused. Did --  
20 did you work on part of Mr. Bystrom's report in  
21 the last instance? Is that what you're saying?  
22 A. What I'm saying is that there was a  
23 report that was generated by both of us that  
24 towards the end of the editing process was split

1 that's up above and below it; that's all taken  
2 from Mr. Bystrom, isn't it?  
3 A. It could have been. I don't -- I  
4 don't recall if it was or not, but it could have  
5 been.  
6 Q. And you haven't attributed any of  
7 this to Mr. Bystrom, have you?  
8 A. I attribute -- there's one --  
9 there's one reference -- particularly when we get  
10 back into the area of NDC blocks and soft edits  
11 and hard edits, I put a reference to that. See,  
12 that would have been --  
13 Q. That's on Page 44.  
14 A. Is that where it is? So you see the  
15 footnote there.  
16 But I didn't -- I was asking if he'd  
17 seen Footnote 51, which he had. But I didn't -- I  
18 didn't footnote every section of the text that I  
19 used from his report.  
20 Q. Actually, what the footnote says,  
21 sir, is that "Many of the definitions used in this  
22 section," and 51 refers -- there's a section here  
23 that's called "Retail Vendors" -- "were developed  
24 in collaboration with Dale Bystrom when we worked

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1 together on the Duramed" -- and has the cite case.  
 2 You see that?  
 3 A. I do.  
 4 Q. Where in this report do you say that  
 5 you're actually quoting or -- or basically taking  
 6 wholesale Mr. Bystrom's entire discussion on a  
 7 particular area and putting it into your report?  
 8 MR. COHEN: Object to the form.  
 9 A. I don't have any other footnotes  
 10 from Mr. Bystrom than the one that's referenced.  
 11 BY MR. DOBIE:  
 12 Q. Why do you say that it -- it says,  
 13 "Many of the definitions used in this section were  
 14 developed in collaboration with Dale Bystrom."  
 15 Why didn't you say most of the section relating to  
 16 the pharmaceutical distribution system, pharmacy  
 17 benefit managers, et cetera, all came from Dale  
 18 Bystrom's report and I simply put it into my  
 19 report?  
 20 MR. COHEN: Object to the form.  
 21 A. I didn't -- it didn't occur to me to  
 22 do it. I could have done that. However, the way  
 23 you describe it wouldn't have been the way I'd  
 24 have footnoted it. I could have put in that

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1 segments of this report were in Dale Bystrom's  
 2 final report and that many or most of those areas  
 3 were areas that I coworked with him on when he was  
 4 developing his report.  
 5 BY MR. DOBIE:  
 6 Q. Okay.  
 7 A. So it didn't seem to me that it was  
 8 the same thing as citing a document that I was  
 9 merely reading and didn't have any involvement in.  
 10 Q. Well, which of the -- which of the  
 11 sections that are in here that didn't come from  
 12 Mr. Bystrom did Mr. Bystrom also work on?  
 13 A. Could you repeat that?  
 14 MR. COHEN: Objection.  
 15 BY MR. DOBIE:  
 16 Q. You said that both of you worked  
 17 collaboratively on one document.  
 18 Okay. So my question for you is,  
 19 are there sections in -- in your report that Mr.  
 20 Bystrom also worked on?  
 21 MR. COHEN: Object to the form.  
 22 A. Yes, there were. And he was able to  
 23 interface with my report on the dispensing  
 24 pharmacy interrelationship with the physician

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1 during the prescribing process.  
 2 BY MR. DOBIE:  
 3 Q. Why did you say on Page 44, 51 -- on  
 4 Foot -- Footnote 51 that it's just many of the  
 5 definitions used were developed in collaboration  
 6 with Dale Bystrom?  
 7 MR. COHEN: Object to --  
 8 BY MR. DOBIE:  
 9 Q. Why did you limit it to "definitions  
 10 used"?  
 11 MR. COHEN: Object to the form.  
 12 Asked and answered.  
 13 THE WITNESS: Say again.  
 14 MR. COHEN: You can go ahead.  
 15 A. The business that Dale Bystrom  
 16 brought to his report that were really unique to  
 17 his report and I had little collaboration in were  
 18 these definitions. You know, the business about  
 19 the NDC, the hard edits, the soft edits. Those  
 20 were his -- those were areas that he had a great  
 21 deal of experience in.  
 22 MR. DOBIE: Why don't we go ahead  
 23 and mark Dale Bystrom's report as Exhibit 8.  
 24 \* \* \*

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1 (Whereupon, Gibson Exhibit 8 was  
 2 marked for identification.)  
 3 \* \* \*  
 4 BY MR. DOBIE:  
 5 Q. I hand you for the record what was  
 6 marked as Exhibit 8. Okay. And if you -- first,  
 7 is this the Dale Bystrom report that you're  
 8 referring to?  
 9 A. I assume that this is his final  
 10 report in the -- in the Duramed case.  
 11 Q. And is it your testimony that you  
 12 wrote part of this report, sir?  
 13 A. It is my -- my statement that I  
 14 collaborated on big portions of this report.  
 15 Q. All right. And if Mr. Bystrom --  
 16 Mr. Bystrom testified that he wrote the entire  
 17 report himself, would that be a lie?  
 18 A. No. He did write the report, but he  
 19 didn't say that he didn't have any input from  
 20 anybody else.  
 21 Q. Okay. But I'm talking about the  
 22 actual verbiage, the words that are here in this  
 23 report. Is it accurate to say that Mr. Bystrom  
 24 wrote these words or did you write the words?

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1 MR. COHEN: Objection. Asked and  
2 answered.  
3 A. Every -- every portion of the final  
4 report he wrote. That's what he turned in. Every  
5 portion of what I turned in I wrote.  
6 BY MR. DOBIE:  
7 Q. Okay. So --  
8 A. And if I could just say, in this  
9 report, everything that I wrote I wrote. Now, I  
10 might have left in it the verbiage from Mr.  
11 Bystrom's report, but it would only have survived  
12 my editing.  
13 Q. All right. Well, let's look, for  
14 example, at Page 12 of your report.  
15 A. Of --  
16 Q. Your report, Exhibit 1. You keep  
17 that handy. Look at Page 12 of your report.  
18 A. My report. Okay.  
19 Q. Keep Mr. Bystrom's report handy as  
20 well.  
21 All right. Now, in your report, you  
22 say -- at the top, you've got the pharmaceutical  
23 distribution system; correct?  
24 A. Correct.

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1 Q. All right. And then if you turn to  
2 Mr. Bystrom's report, at Page 5, he also has -- at  
3 the top, it says the pharmaceutical distribution  
4 system; right?  
5 A. Right.  
6 Q. And then you've added -- in your  
7 report, you've got a paren that says "wholesalers,  
8 mail order, and retail sales." You've added a  
9 first sentence that you wrote and then the rest of  
10 the paragraph you just lifted directly from the --  
11 Bystrom's report, which you said he would have  
12 wrote the language that appeared in his final  
13 report; correct?  
14 MR. COHEN: Object to the form.  
15 A. Correct.  
16 BY MR. DOBIE:  
17 Q. And you didn't put a citation here  
18 for Mr. Bystrom, did you?  
19 A. No.  
20 Q. And you don't put it in quotes, do  
21 you?  
22 A. No.  
23 Q. And if you go to the paragraph right  
24 behind -- right below the graph that you took from

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1 Mr. Schondelmeyer, that's also from Mr. Bystrom,  
2 the next two paragraphs as well; correct?  
3 A. Correct.  
4 MR. COHEN: Objection.  
5 BY MR. DOBIE:  
6 Q. And again no quotation to Mr. -- to  
7 Mr. Bystrom or citation to him; correct?  
8 A. Correct.  
9 Q. And if we go to the bottom of the  
10 page under the pharmaceutical payment system,  
11 where it says "Payment Cycle for Pharmaceuticals,"  
12 that too was lifted from Mr. Bystrom; correct?  
13 A. Portion of it was. He didn't have  
14 the graphic --  
15 Q. The graph you took from Mr.  
16 Schondelmeyer; correct?  
17 A. Correct.  
18 Q. Right. And then if we go on to  
19 the -- to the next page, 13, that all comes from  
20 Mr. Bystrom as well, doesn't it?  
21 A. Could you -- would you like me to --  
22 Q. Well, let's go -- go to the first  
23 paragraph here, Page 13. "Pharmacy patients can  
24 be divided into two categories" and so on. That's

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1 from Mr. Bystrom on Page -- Page 5? It's the  
2 second paragraph.  
3 A. Page 5, the second paragraph.  
4 Q. So if you're looking at Mr.  
5 Bystrom's report on Page 5, under the payment  
6 cycle for pharmaceuticals, the second paragraph  
7 where it says, "Pharmacy patients can be divided  
8 into two categories"?  
9 A. Yes.  
10 Q. Okay. So you took that paragraph  
11 from Mr. Bystrom's report?  
12 MR. COHEN: Object to the form.  
13 A. Correct.  
14 BY MR. DOBIE:  
15 Q. Right. And then the next paragraph  
16 where it says, "The payment cycle for  
17 pharmaceuticals begins at the pharmacy with  
18 patient and/or patient health plan," that too came  
19 from Mr. Bystrom's report; correct?  
20 A. Correct.  
21 Q. And if we go through the pages  
22 again, there's -- there's page after page that's  
23 just lifted directly from Mr. Bystrom's report --  
24 MR. COHEN: Object --

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1 BY MR. DOBIE:

2 Q. -- without any quotation or

3 attribution to him; correct?

4 MR. COHEN: Object to the form.

5 A. Correct.

6 THE VIDEOGRAPHER: Stand by.

7 (Pause.)

8 THE VIDEOGRAPHER: Proceed.

9 BY MR. DOBIE:

10 Q. Is there any other work that you

11 believe is necessary for you to do, sir, to form

12 an opinion on the issues that you've been asked to

13 render an opinion on?

14 A. Is there any --

15 Q. Is there other work that you need to

16 do in order to form an opinion on any of the

17 issues on which you've been asked to render an

18 opinion?

19 MR. COHEN: Object to the form.

20 A. I believe that I have completed the

21 work necessary to -- to back up the report that I

22 turned in.

23 BY MR. DOBIE:

24 Q. All right. Is there any -- does the

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1 report represent a complete statement and the

2 basis and the reasons for your opinion?

3 A. Yes.

4 Q. And is there any other work that you

5 feel you need to do in order to feel confident

6 about the opinions and conclusions that are set

7 forth in your report?

8 A. No.

9 MR. DOBIE: It's 1:15. You guys

10 want to take a -- try to do a quick lunch

11 today?

12 MR. COHEN: Yes.

13 THE VIDEOGRAPHER: We're going off

14 the record. The time is 1:20 p.m.

15 \* \* \*

16 (Whereupon, a luncheon recess was

17 taken.)

18 \* \* \*

19

20

21

22

23

24

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1 \* \* \*

2 AFTERNOON SESSION

3 \* \* \*

4 (Whereupon, Gibson Exhibit 9 was

5 marked for identification.)

6 \* \* \*

7 THE VIDEOGRAPHER: We're back on the

8 the record. The time is 2:03 p.m.

9 BY MR. DOBIE:

10 Q. Dr. Gibson, in -- in preparing your

11 report, you mentioned the outline process that you

12 had gone through towards working on the final.

13 Do you have copies of any of those

14 outlines?

15 MR. COHEN: Could I just interpose,

16 Gordon, I think the agreement in the case is

17 that we're not going to be exploring drafts

18 or any of that type of thing.

19 MR. DOBIE: Let's -- let's go off

20 the record just for a second.

21 THE VIDEOGRAPHER: We're going off

22 the record. The time is 2:03 p.m.

23 \* \* \*

24 (Whereupon, a discussion was held

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1 off the record.)

2 \* \* \*

3 THE VIDEOGRAPHER: We're back on the

4 record, 2:05 p.m.

5 BY MR. DOBIE:

6 Q. Dr. Gibson, I'm not sure whether you

7 have drafts or not. What -- what counsel is

8 telling me is that there's apparently an agreement

9 in place that the parties aren't going to take or

10 try to get copies of each other's drafts and

11 things like that.

12 I assume that this is -- though, is

13 something that you did prepare on your computer;

14 correct?

15 A. Correct.

16 Q. Okay. And worked out over the

17 course of some time period?

18 A. Correct.

19 Q. And in addition to the things that

20 we covered before we broke for lunch, let me show

21 you the next document that I marked in this

22 series. This is Gibson Exhibit 9, and for the

23 record, have you ever seen this before?

24 A. Was this the -- was this the

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1 reference document that I gave you in the -- as  
 2 footnoted in my report?  
 3 Q. I believe that you did cite this in  
 4 your report, yes, sir.  
 5 A. Then I saw this.  
 6 Q. Okay. You reviewed this?  
 7 A. The main reason I went out and  
 8 sought this information was to be able to identify  
 9 AIS.  
 10 Q. And what is AIS, for the record?  
 11 A. It's primarily a publisher of --  
 12 it's a company that -- that writes articles and  
 13 publishes them in business-like periodicals. And,  
 14 for instance, they issued here Managed Care Weekly  
 15 and -- oh, and Managed Care Weekly.  
 16 Q. And if you turn to your report,  
 17 which is Exhibit 1, and go to Page 16.  
 18 A. Okay.  
 19 Q. You actually have simply just lifted  
 20 wholesale from this document and put it into your  
 21 report; correct?  
 22 MR. COHEN: Object to the form.  
 23 A. The -- let's see. We're -- we're on  
 24 Page 16?

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1 BY MR. DOBIE:  
 2 Q. Yes. So if you start at the bottom  
 3 under "Effect on Employers."  
 4 A. I see. Okay.  
 5 Q. Starting with the second sentence,  
 6 "As companies put the finishing touches on 2004  
 7 employer benefit design changes," those two  
 8 paragraphs are set forth in your expert report on  
 9 the bottom of Page 16 running over to 17; correct?  
 10 A. Right. They were getting back to  
 11 the article on managing direct costs in Managed  
 12 Care Weekly.  
 13 Q. Okay. And again, why did you not --  
 14 why didn't you put quotations that you had  
 15 actually just quoted this directly from -- from  
 16 the managed drug cost article here on pharmacy  
 17 benefit management?  
 18 A. I thought my footnoting was  
 19 adequate.  
 20 Q. Okay. Is it -- your normal practice  
 21 is if --  
 22 A. Yes.  
 23 Q. -- something's written in the New  
 24 England Journal of Medicine that you -- if you

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1 were going to just quote articles, that you would  
 2 attribute the language to the actual author of the  
 3 article?  
 4 MR. COHEN: Objection.  
 5 Argumentative.  
 6 A. Not necessarily -- I would not  
 7 necessarily quote the exact -- if I -- if I put a  
 8 quote in, it's -- if I put a footnote in, it's  
 9 where I'm getting the material, but I don't  
 10 necessarily always put quotations around it.  
 11 BY MR. DOBIE:  
 12 Q. You don't?  
 13 A. No.  
 14 Q. All right. And so throughout this  
 15 report, do you know how much of this report  
 16 actually has your language and how much of it has  
 17 language that came from another source?  
 18 MR. COHEN: Object to the form.  
 19 A. I'd say most of it is my own  
 20 writing. I have used sources similar to this and  
 21 what we discussed earlier. Most of my opinion or  
 22 all of my opinion is my own writing.  
 23 BY MR. DOBIE:  
 24 Q. Do you think that as much as 50

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1 percent of your report was simply lifted from  
 2 other sources and then moved into your report?  
 3 MR. COHEN: Object to the form.  
 4 A. I don't -- I'm sorry. When I --  
 5 when I used other material, I usually footnoted  
 6 it. This article particularly dealing with  
 7 factual material is heavily footnoted. Whether I  
 8 pulled the material and paraphrased it or used  
 9 directly out of the article, I'm -- I'm not  
 10 prepared to say what percentage.  
 11 BY MR. DOBIE:  
 12 Q. Okay. Well, you're the one who  
 13 prepared your report. Do you remember what your  
 14 process was for doing it?  
 15 A. I -- if -- if the material agreed  
 16 with what I wanted to say, I might use that and I  
 17 generally footnote it.  
 18 Q. Okay. Again without -- without --  
 19 A. Without quotations.  
 20 Q. Without quotation marks. So, for  
 21 example, the next two paragraphs of your report as  
 22 well as on Page 17, "The most common plan design  
 23 changes for 2004," that's -- again, if you look at  
 24 the second page of Exhibit 9, that's the same

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1 language that's in your report; correct?

2 A. Which is what I wanted to say.

3 Q. And if you go down to the -- let's

4 see, two more paragraphs in the article where it

5 says, "Employers generally are more aggressive" --

6 A. Uh-huh.

7 Q. -- than are health insurers in

8 pushing" -- right. There what you've done is

9 you've edited out the fact that that was actually

10 a quote from AdvancePCS's CEO, David Halbert;

11 correct?

12 A. Yes.

13 Q. All right. So this is a quote from

14 the chief executive officer of AdvancePCS and

15 you've removed that and then just put that in

16 your -- in your report; correct?

17 A. Correct.

18 Q. All right. And then the next

19 paragraph that starts, "Employers are now" --

20 "generally are more aggressive," that's again word

21 for word taken from this article with the

22 exception that you removed the fact that that

23 again came from Mr. Halbert, the chief executive

24 officer of AdvancePCS; correct?

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1 A. Correct.

2 MR. COHEN: Object to the form.

3 BY MR. DOBIE:

4 Q. Now, when you remove or use language

5 that's like this, what effort did you make, sir,

6 to check the information that's contained in -- in

7 the article?

8 MR. COHEN: You're referring to

9 Exhibit 9?

10 MR. DOBIE: Yes, sir.

11 BY MR. DOBIE:

12 Q. So the article says, for example,

13 "As companies put their" -- "the finishing touches

14 on 2004 employee benefit design changes, they are

15 stepping up adoption of time-tested approaches to

16 slow spending on prescription drugs - and are

17 evaluating a few new strategies."

18 What -- what did you do to confirm

19 the accuracy of the statement that's in this --

20 this article that you've quoted from?

21 A. That's -- that -- any time I quoted

22 something like that or use material from something

23 like that, if it -- if it was consistent with my

24 experience in operational environment within a

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1 PBM, I didn't go further. And this is completely

2 consistent with what I hear on a daily basis

3 within PCN environment.

4 Likewise, I could add just one other

5 piece. It's very consistent with information I

6 get from working with the consultants in the

7 marketplace and with the ERISA trust and

8 Taft-Hartley trust that we're working with with

9 Illumination.

10 Q. Okay. But go to the -- go to the

11 next paragraph there. It says, "Techniques like

12 mandatory mail order fulfillment requirements and

13 a four-tier pharmacy design have been around for a

14 few years but used by a minority of payers." Do

15 you see that?

16 A. I do.

17 Q. Okay. How would you know, sir,

18 whether it was used by a minority or a majority of

19 payers other than from taking it from this

20 article?

21 A. If you'll go ahead and look at the

22 documentation in the balance of the report, you'll

23 see the actual percentage numbers that relate to

24 tiers and copayments drawn from authoritative

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1 industry sources.

2 Q. Okay. But those -- again, those

3 are -- those are other materials that you have

4 taken from other industry sources and just put

5 into your report; correct?

6 A. I used other industry sources in my

7 report to buttress issues of fact.

8 Q. Okay. But, I mean, just an example,

9 if you look at your report and you go to -- let's

10 just -- let's just use one as an example. Page --

11 Page 13 we were looking at before, the chart

12 that's there.

13 A. Uh-huh.

14 Q. Okay. You as an expert, sir, have

15 put into your report -- you've got the source of

16 payments for prescription drugs 1999. This is --

17 this is something that you have taken from another

18 study and again placed it into your report;

19 correct?

20 A. Correct.

21 Q. All right. But you don't know, for

22 example, whether in 1999 28 percent of

23 prescription drugs were purchased through chain

24 pharmacies or 6.8 percent through mass merchandise

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1 pharmacies or so on. You haven't done any  
2 investigation into the accuracy of any of the  
3 numbers that are contained in this chart; correct?

4 A. What I -- what I -- what I know is  
5 that the chart in general is consistent with my  
6 understanding of how the market structures,  
7 functions, and I pulled the chart from an  
8 authoritative source.

9 Q. Okay. But to answer my question,  
10 you don't know whether or not any of the numbers  
11 that are in this chart are accurate; correct?

12 MR. COHEN: Objection. Asked and  
13 answered.

14 A. I did not verify back to original  
15 research any of the numbers on the chart.

16 BY MR. DOBIE:

17 Q. All right. And you've never --  
18 other than as an expert in this case, you've never  
19 had a reason in your experience, sir, to prepare  
20 or put together any chart like this yourself, have  
21 you, breaking down the amount of -- whether  
22 between private insurance, public insurance,  
23 pharmacy benefit managers on a nationwide basis,  
24 how payment for prescription drugs works across

1 published information roughly what their  
2 percentage of the market they represent. So I  
3 know Bergen, for instance, is the wholesaler  
4 that -- that works with most of them and I've have  
5 had many conversations with Bergen as to what  
6 percentage of the market the independent  
7 pharmacies are.

8 So it's not -- the point I'm making  
9 is I have verified everything in this report from  
10 various sources just by the fact that I'm involved  
11 in the market on a daily basis.

12 Q. Has anyone ever hired you, sir, to  
13 examine the -- to prepare any analysis that's like  
14 on Page -- Page 13 of your report, the source of  
15 payment for prescription drugs, to do that type of  
16 an analysis?

17 We've gone through all your jobs and  
18 we can go back to them. I got all night.

19 A. The closest I would get to -- to an  
20 affirmative on that would be that I have worked  
21 within PCN and the contracting officers for their  
22 network. It has been within that context that  
23 I've gotten an understanding of what these  
24 independent pharmacies are like, how many of them

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1 the country?

2 A. No, that's not correct. I -- when  
3 I'm working with segments of the market, I have to  
4 understand their footprint in the industry. So  
5 that when I'm dealing with ERISA trusts or a more  
6 recent example is with the independent pharmacists  
7 in southern California, I get a feel in that  
8 engagement as to how big a footprint in the  
9 industry I'm dealing with. And these numbers are  
10 quite consistent with all of that background.

11 Q. All right. Take -- take the example  
12 you just gave. Pharmacists that want to dispense  
13 a pharmaceutical product rather than having  
14 doctors do that in southern California. Okay.  
15 How does your background in doing that give you a  
16 foundation to know that the source of payment for  
17 prescription drugs in 1999 came 64 percent from  
18 private insurance, 19.7 percent from public  
19 insurance, and so on, all the numbers that -- that  
20 are in here?

21 A. I know -- I know from the fact that  
22 the independent pharmacists are my clients. I  
23 know during my conversations with them where their  
24 payment sources generally come from. I know from

1 they -- how -- how populous they are within the  
2 networks. And I've got a feel for where they get  
3 their product and where they get paid.

4 Q. Okay. I understand you have a  
5 general sense, okay, as somebody who's been in the  
6 industry. All right. But as -- I mean, certainly  
7 there are -- there are people, for example, the  
8 folks that prepared this chart that you've now put  
9 in your report, that actually have done studies  
10 like this and have an understanding as to the  
11 accuracy of the numbers that are in that chart.

12 And my point is, you might have a  
13 general feel that yes, money comes from private  
14 insurance, public insurance, and then goes down to  
15 either retail pharmacies or institutional  
16 pharmacies and on its way down to corner  
17 drugstores and hospitals and stuff, but can you  
18 attest under oath in front of a jury as to the  
19 accuracy of the information that's here?

20 MR. COHEN: Objection.

21 Argumentative. Asked and answered.

22 A. I can attest to the fact that I  
23 pulled the data from an authoritative source.  
24 BY MR. DOBIE:

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1 Q. Okay. And what's the authoritative  
2 source?  
3 A. Mr. Schondelmeyer I believe is the  
4 authoritative source on this one.  
5 Q. Okay. And --  
6 A. This was -- this was a slide that he  
7 used in a presentation to the World Bank.  
8 Q. And where did you get it? Off the  
9 Web?  
10 A. I either got it off the Web or out  
11 of an article that he had written earlier.  
12 Q. And do you know what Mr.  
13 Schondelmeyer did to determine the accuracy of the  
14 information that's contained here?  
15 A. I looked at his material and the  
16 sources that he used, and in general he's pulling  
17 data from published material that he's used  
18 before.  
19 Q. Okay. Have you had discussions with  
20 Mr. Schondelmeyer about this data?  
21 A. No.  
22 Q. All right. In the preparation  
23 for -- for the other charts that are in your  
24 report, for example, on Page 12, that also came

1 One is that you have a detailed  
2 knowledge of -- and background on every issue that  
3 you -- or every detail that you put in the report.  
4 For instance, the slides that you've referenced  
5 here in this last set of questions, knowing that a  
6 given percentage of the distribution of product  
7 goes to a given section would be a very few people  
8 in the country that would actually know that. You  
9 would generally rely upon referenced authoritative  
10 sources. Likewise, there are other areas within  
11 the report, for instance, dealing with rebates,  
12 you could argue that the advantages to have  
13 actually negotiated a rebate to be able to render  
14 an authoritative opinion on rebate contracts.  
15 There's a second way, however, to  
16 look at all of this, which is where I come from on  
17 preparing this report. My background gives me a  
18 broad overview of how the health care system  
19 works. I -- on creating the report as it related  
20 to background information and data, I would pull  
21 information that was consistent with my broad  
22 experience in the industry, and that's how I would  
23 include these items.  
24 BY MR. DOBIE:

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1 from --  
2 A. Same source.  
3 Q. -- from -- it says "PRIME Institute,  
4 University of Minnesota."  
5 A. That's Mr. Schondelmeyer's  
6 institute.  
7 Q. Okay. And again, I assume you  
8 haven't discussed it with Mr. Schondelmeyer?  
9 A. No.  
10 Q. And you haven't done anything to  
11 confirm the accuracy of the numbers that are  
12 contained in this chart?  
13 A. Correct.  
14 Q. Just a general matter, I just want  
15 to understand how -- when you're putting your  
16 expert report together and you're going around on  
17 the Web finding things that you think are  
18 supportive of your experience and then putting  
19 them into your report, what was the -- what was  
20 the standard that you applied in determining  
21 whether or not you'd include it or not?  
22 MR. COHEN: Object to the form.  
23 A. There are two ways to look at  
24 generating a report like this in my mind.

1 Q. Okay. So let me -- let's -- let's  
2 just use another example.  
3 MR. COHEN: I'm sorry. Were you  
4 finished with your -- your answer?  
5 A. I was just going to say that I come  
6 at this from the perspective of understanding the  
7 mosaic, not the -- not the placement of one -- one  
8 of the tiles within a mosaic. And I did not add  
9 anything to my mosaic that I was not comfortable  
10 with and was not consistent with my overview of  
11 how the industry works.  
12 \* \* \*  
13 (Whereupon, Gibson Exhibit 10 was  
14 marked for identification.)  
15 \* \* \*  
16 BY MR. DOBIE:  
17 Q. Okay. Let's look at Exhibit 10 for  
18 a moment. And for the record, Exhibit 10 is what,  
19 sir?  
20 A. It is pulled from the Web from a  
21 source that is entitled "HealthLeaders."  
22 Q. Okay.  
23 A. Information to lead.  
24 Q. And what is HealthLeaders?

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1 A. I believe HealthLeader is a -- I  
2 believe that they are a publication. I'm not  
3 certain of that.  
4 Q. Have you ever used HealthLeaders  
5 before for anything?  
6 A. I'm certain I've run across them in  
7 general reading, but no.  
8 Q. Do you know Mr. Dickman, who is the  
9 author of the article?  
10 A. I know that the exhibit here says  
11 "By Tim Dickman."  
12 Q. Do you know Mr. Dickman?  
13 A. No.  
14 Q. Do you know whether or not he's an  
15 authoritative source for the information that's  
16 contained in the article?  
17 A. I -- no, I don't know much about Mr.  
18 Dickman.  
19 Q. Do you consider HealthLeaders an  
20 authoritative source for the information?  
21 A. It is -- I consider it to be a --in  
22 the general category of trade journals.  
23 Q. All right. And so does that mean  
24 it's authoritative in your view?

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1 A. I think it's -- I think it's a  
2 reliable source of information.  
3 Q. Have you ever heard of it before you  
4 did your report?  
5 A. I don't recall. I think I have.  
6 Q. And what about the AIS Pharmacy  
7 Benefit Group in this article that we marked  
8 previously as Exhibit 9; is that an authoritative  
9 source of information?  
10 A. That was a source in a source that  
11 was authoritative.  
12 Q. What's the source within the source?  
13 A. If you'll pull --  
14 Q. It's right here.  
15 A. No. But if you will pull the -- I  
16 will have to go through my report to get it for  
17 you, but one of the slides that I included  
18 contained AIS as a source.  
19 Q. Okay. And in going back to the  
20 HealthLeaders article --  
21 A. Do you want to stay on this point or  
22 not?  
23 Q. I heard your answer.  
24 A. Okay.

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1 Q. Exhibit 10, if we could turn to  
2 that.  
3 A. I'm sorry. Can I just tell you?  
4 Q. Sure.  
5 A. It was on Page 37 and it was the --  
6 AIS was the source for the slide dealing with  
7 tiered copayment structures.  
8 Q. Okay.  
9 A. And as an example, that tiered  
10 copayment structure looks about right.  
11 Q. For what time period, sir?  
12 A. This was back in the early 2000s.  
13 This I think was referenced at 2002.  
14 Q. All right. And when you say it  
15 looks about right, what about it looks right to  
16 you, sir?  
17 A. The definition of how the -- what --  
18 what it says on the slide as far as your tiered  
19 copayment, and I don't believe this particular  
20 copy that I have has all of the information on it.  
21 There may have been information above the columns.  
22 But you have -- you have a general definition of  
23 what the copayment is for a brand versus a  
24 generic.

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1 And then on the first tier and on  
2 the second tier, it goes on to 15-20 for the first  
3 month's supply and brand name drug with no generic  
4 equivalent, and it generally outlines what the  
5 tiered structure would look like, and that's  
6 certainly consistent with my experience.  
7 Q. All right. And the years that AIS  
8 was looking at in connection with the preparation  
9 of this chart, do you know if it's 2001, 2002, or  
10 2000?  
11 A. I don't know, but I don't think it  
12 makes much difference.  
13 Q. All right. Okay. And so when  
14 you're saying that this is consistent with your  
15 experience, do you know whether or not, just for  
16 example, a third-tier copay in 2002 was on average  
17 between \$25 to \$30?  
18 A. I think that's consistent with my  
19 understanding. I have more authoritative sources  
20 quoted in the -- in the text.  
21 Q. Do you know in 2000 whether the  
22 third-tier copays were between 25 and 30?  
23 A. I would refer you to -- on Page 36.  
24 This is data from 1999 and this is IMS, which is

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1 probably the most authoritative source.

2 Q. Okay. And what --

3 A. And then just below that average

4 copayments, which is what you're asking for, in

5 the year 2002, and I use the reference Scott

6 Levin, which is pulled directly from Wyeth's

7 documents.

8 Q. All right. So in 2002, for example,

9 the Wyeth document says it's \$34, is the average

10 co -- copayment. The document that you have on

11 the next page of your report says it's 25 to 30

12 dollars.

13 What -- what is correct, or don't

14 you know?

15 A. I don't know for sure.

16 Q. All right.

17 A. And I don't think again it makes a

18 lot of difference.

19 Q. But at the end of the day, what you

20 did in preparing in your report, sir, is you just

21 took information from -- from other sources and

22 put it in your report?

23 A. Yes. I did not go out to the market

24 and do a market research study on what the

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1 copayment values were by year to put in my report.

2 Q. And, in fact -- let's go back to

3 Exhibit 10. What you did do in your report is --

4 this is another -- it's right next to you. This

5 is another example where you have simply taken

6 information from another author, put it in your

7 report without quotations, and then referenced the

8 source generally after the quotation; correct?

9 A. I did not -- I did not put

10 quotations. I did reference the article.

11 Q. All right.

12 A. And I did not put in material that I

13 did not find consistent with my experience.

14 Q. In the -- on Page 23 of your report,

15 in the first paragraph on that page where it says,

16 "Critics charge, not altogether unfairly, that the

17 current rebate structure" -- do you see that?

18 A. I do.

19 Q. That was just lifted from the

20 HealthLeaders article word for word, wasn't it?

21 A. It could be. Do you -- do you have

22 the point on the HealthLeaders article where it

23 came from?

24 Q. Well, you wrote your report, sir.

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1 Do you remember where you got it?

2 A. Well, give me a minute and I'll look

3 over the paper.

4 Q. Look in the -- under "Disclosure of

5 Rebates," the second paragraph.

6 A. Yes. That's -- that's what's in

7 this article.

8 Q. Okay. Who are the critics that Mr.

9 Dickman is referring to?

10 A. I don't know for sure who Mr.

11 Dickman was referring to. I do know that what the

12 verbiage says is consistent with the -- over the

13 general reading I have done and the critical

14 comments about the rebate structures and PBMs'

15 method of doing business, and it's -- all you

16 would have to do is read the Wall Street Journal

17 to -- to confirm that.

18 Q. Okay. So somebody reading the Wall

19 Street Journal would understand that critics are

20 charging, not -- not altogether unfairly that the

21 current rebate structures create built-in

22 conflicts of interest?

23 A. It's the basis for --

24 MR. COHEN: Object to the form.

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1 A. It's the basis for most of the suits

2 that attorneys general in New Jersey -- in New

3 England and elsewhere have been filing against

4 PBMs, particularly the Merck-Medcos.

5 BY MR. DOBIE:

6 Q. Okay. And so Mr. Cohen, for

7 example, could he read this article and by the

8 same token reach the same conclusion?

9 MR. COHEN: I'm probably a bad

10 example.

11 A. I think any reasonable observer of

12 the industry reading regularly both the lay and

13 professional literature could make that statement.

14 BY MR. DOBIE:

15 Q. Okay. And is that true for -- for

16 most of this background material that you have,

17 sir, where you've -- where you've taken it from

18 other sources?

19 A. Well, some of it, I've taken it from

20 others and some of it is -- is text that I've

21 generated. And I've -- your -- we've made --

22 you've the point several times that I didn't use

23 the quotation marks, but I did try to put in the

24 references where I pulled material from.

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1 Q. In the discussion that you had  
2 previously about -- let me back up a little bit.  
3 The reference previously -- with the  
4 exception of Mr. Bystrom's report; right? The  
5 only reference to Mr. Bystrom's report is in that  
6 footnote that we were looking at before on Page  
7 44; right?  
8 A. Correct.  
9 Q. All right. This -- this process  
10 that you described before that you and Mr. Bystrom  
11 went through to prepare the reports in the Duramed  
12 case, do you -- do you keep a computer, sir, at  
13 your home?  
14 A. Sure.  
15 Q. And what kind of computer do you  
16 have?  
17 A. It's a desktop computer. It's made  
18 by -- what's the company that looks like cows?  
19 Q. Gateway?  
20 A. Gateway.  
21 Q. How long have you had that computer,  
22 sir?  
23 A. Three years -- three years or so.  
24 Q. So did you have it at the time that

1 A. Correct.  
2 Q. And since your deposition, you  
3 haven't gained any experience in terms of  
4 negotiating with manufacturers of -- of  
5 pharmaceutical products; correct?  
6 A. Direct contracting, no.  
7 Q. And you haven't negotiated any  
8 market share rebates or anything like that with  
9 any pharmaceutical companies since your -- your  
10 last deposition; correct, sir?  
11 A. Correct.  
12 Q. And given that you haven't  
13 negotiated rebate contracts with any  
14 manufacturers, sir, do you know how common  
15 exclusives are in the industry?  
16 MR. COHEN: I'm sorry. Can you read  
17 that question back? I didn't -- I didn't  
18 quite get it.  
19 MR. DOBIE: Yes, I'll just restate  
20 it.  
21 BY MR. DOBIE:  
22 Q. At the time of your last deposition,  
23 sir, you told me that you had never negotiated a  
24 rebate contract with a manufacturer and it's not

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1 you did your report in the Duramed case?  
2 A. I don't recall if I had it at that  
3 time or not.  
4 Q. Do you use e-mail?  
5 A. Yes.  
6 Q. Have you had the same e-mail service  
7 in the last three years?  
8 A. MSN.com.  
9 Q. Do you have any other computers  
10 besides the Gateway?  
11 A. Yes. I have a laptop that's  
12 provided to me by PCN and I have a PCN e-mail  
13 address.  
14 Q. How long have you had the laptop  
15 that you got from PCN?  
16 A. From the time I started with the  
17 company.  
18 Q. Sir, I want to talk about your  
19 experience with contracting with pharmaceutical  
20 companies.  
21 At the time of your last deposition,  
22 you told me that you didn't have any experience  
23 negotiating with manufacturers of pharmaceutical  
24 products; correct?

1 something that you had -- because of that, you  
2 didn't have knowledge of how common exclusive  
3 contracts were in the industry; correct?  
4 A. Correct.  
5 Q. All right. And you still don't?  
6 A. Incorrect. Since that time two  
7 years ago, I've been in an operating environment  
8 in a PBM. I didn't negotiate the contracts, but  
9 i've had regular conversations with people who do.  
10 Q. Who do you have regular  
11 conversations with at PCN that negotiate rebate  
12 contracts?  
13 A. There was -- one of the  
14 pharmacists -- first of all, I visited with John  
15 Scull, who is the CEO of the company. I visited  
16 with David -- I can't remember the name. The  
17 chief financial officer for the company who's  
18 regularly involved in these negotiations. And  
19 there is -- there was a pharmacist that was  
20 involved. His name is -- let's come back to that  
21 and I'll give it to you. It's just -- I'm not --  
22 I didn't come prepared to give you that -- his  
23 name. But --  
24 Q. It's a he?

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1 A. It's a he.

2 Q. And what's your understanding of his  
3 responsibility, this pharmacist?

4 A. His -- his responsibility was the  
5 lead negotiator on the rebates when we brought the  
6 formulary back inhouse.

7 Q. And is this somebody who's an  
8 existing employee?

9 A. No, he's no longer with PCN, but he  
10 was up until about the last month.

11 Q. Okay. So in the process of  
12 preparing a formulary for PCN, did you have  
13 discussions with the CEO of PCN, this pharmacist  
14 that you can't remember the name of, and the CFO  
15 concerning the question of how common exclusives  
16 were in their experience?

17 A. I asked that question, how often do  
18 you see exclusive contracts negotiated, and  
19 furthermore how often do you see these tied  
20 contracts where you are tying multiple products  
21 together. And the answer I got -- what was that?

22 Q. I was just asking you if the CEO and  
23 the CFO had never before themselves negotiated a  
24 manufacturer contract because PCN hadn't been

1 have percentages attached to it, but it was -- it  
2 was not a common thing, and it was particularly  
3 uncommon to have these tied relationships,  
4 product-tied relationships.

5 Q. Okay. Let's make sure I understand  
6 it.

7 Who was it that told you first that  
8 exclusives are not that common?

9 A. It is -- the first person that told  
10 me that was John Scull. The second person was  
11 David -- I want to say Norwood, but that's not  
12 right. And the third was this pharmacist that I'm  
13 having trouble with his name right now.

14 Q. And they were telling you that based  
15 upon this -- when was it that you had this  
16 discussion with them?

17 A. When?

18 Q. Yes, sir.

19 A. Some time in the last year.

20 Q. Okay. So in -- was it you were  
21 asking them what were they seeing in the course  
22 of -- of contracts that were being offered to  
23 PCN --

24 A. Right.

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1 doing that.

2 A. No, but they've been involved since  
3 we brought it back inhouse.

4 Q. In 2003?

5 A. Correct.

6 Q. Okay. So in --

7 A. And I'm just telling you that things  
8 changed from my last -- from our last visit  
9 together till now where we have an operating PBM  
10 environment where this is routinely done.

11 Q. All right. So here's what I'm  
12 getting at. So you were asking them now that  
13 we've brought it back inhouse, what are you seeing  
14 in terms of what manufacturers are asking for in  
15 terms of exclusive contracts?

16 A. No. I had been involved in the  
17 Duramed case.

18 Q. Right.

19 A. And so I was curious. Is this -- I  
20 wasn't going to go into great detail, because I  
21 had all the confidentiality agreements with the  
22 Duramed. But I just asked in general do you see  
23 often these exclusive relation -- contracts, and  
24 the answer was it's not that common. It didn't

1 Q. -- during 2003?

2 A. Yes.

3 Q. Okay.

4 A. And -- and I would just say also  
5 that -- and I apologize for the fact that I'm not  
6 giving you the name right now, but the contracting  
7 officer, the pharmacist that I'm referring to, had  
8 also done this contracting at another PBM in the  
9 past. So it wasn't just he'd been brought in from  
10 the outside to help with this.

11 Q. Okay. And the other person that --  
12 you had John Scull, and then the CFO of the  
13 company is the other person that told you this?

14 A. I don't recall that the CFO told me.  
15 It was John Scull and this contracting officer.

16 Q. And the contract officer. Okay.  
17 And they both told you that based upon the --

18 A. Their experience and understanding.

19 Q. Can I finish the question, sir?

20 A. Yes.

21 Q. They told you that based upon --  
22 let's start with Mr. Scull first. All right.  
23 Strike the question.

24 Mr. Scull told you that in this time

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1 period since PCN began handling its own contracts  
2 with manufacturers, which began in 2003, that he  
3 did not find that exclusive contracts were that  
4 common; is that correct?

5 A. That was not the question I asked  
6 nor the question that he answered.

7 Q. All right. Well, tell --

8 A. The question I asked was, is it  
9 your -- is it your experience based on both  
10 branded formulary inhouse and on your general  
11 understanding of the industry, because he's been  
12 in it for many years -- is this an unusual thing  
13 to see, and the answer was that I told you.

14 Q. Okay. So Mr. Scull told you that  
15 exclusives were not that common?

16 A. Correct.

17 Q. All right. And did he say that  
18 exclusives were uncommon?

19 A. I don't recall that he said it was  
20 uncommon. He just said that he didn't see it that  
21 often.

22 Q. Did he tell you that PCN had  
23 exclusives?

24 A. I don't recall that he told me.

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1 Q. Did -- did you come to find out that  
2 PCN had exclusives?

3 A. I didn't pursue it further.

4 Q. You had the discussion with this  
5 pharmacy who is the contract manager --  
6 pharmacist?

7 A. Correct.

8 Q. Okay. And tell me exactly what he  
9 said in terms of whether or not exclusives were  
10 common.

11 A. It was consistent with what John  
12 Scull had told me and that I related in this  
13 testimony.

14 Q. Okay. But I want to be as precise  
15 as possible.

16 This pharmacist told you that  
17 exclusives were not that common?

18 A. Correct.

19 Q. And did he say that PCN had, in  
20 fact, exclusives?

21 A. He didn't tell me that.

22 Q. Did he say exclusives were not  
23 uncommon?

24 A. He said they were not common.

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1 Q. Did you -- did you -- after -- after  
2 hearing this, did you yourself inquire as to  
3 whether or not by exclusive -- let me back up.

4 When you asked him about exclusives,  
5 were you talking about the only drug in a  
6 therapeutic class?

7 A. Yes.

8 Q. Okay. And -- and so when they said  
9 that an exclusive -- exclusive is not that common,  
10 they were saying that it's within a therapeutic  
11 class; correct?

12 A. Generally we would offer a couple or  
13 more of brand products within a class.

14 Q. All right. And so, for example, in  
15 the estrogen category, estrogen replacement  
16 therapy category, PCN does, in fact, offer a  
17 variety of products in that category; correct?

18 A. Correct.

19 Q. It does not have an exclusive on --  
20 on conjugated estrogens; correct?

21 A. I don't know.

22 Q. All right. And does it have a --

23 A. Let me just back up one second.

24 It's very important here on

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1 definitions. For instance, what tier are we on  
2 here? In other -- you know, are you asking was  
3 conjugated -- was Premarin the only conjugated  
4 estrogen or the family of Premarin the only  
5 conjugated estrogens on the second tier and -- and  
6 the third tiers --

7 Q. That's not my question.

8 A. -- are different?

9 Q. My -- my question is -- I'm  
10 following up with you on your discussions with Mr.  
11 Scull and with the pharmacist, the person that's  
12 the contract manager. All right. And when  
13 they're saying that exclusives are not that  
14 common, what they were saying is that exclusives  
15 are not that common in the therapeutic category,  
16 within a therapeutic category?

17 A. Yes.

18 Q. You would not have only one branded  
19 product within a whole therapeutic category;  
20 correct?

21 A. It would be unusual.

22 Q. All right. Do you know whether PCN,  
23 in fact, has any exclusives within an entire  
24 therapeutic category?

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1 A. No, I don't.  
 2 Q. So as the head of the P&T committee,  
 3 have you ever reviewed PPIs, for example, at PCN?  
 4 A. We did review -- let's see. Did we?  
 5 We reviewed SSIs. I don't know -- I don't recall  
 6 if we reviewed PPIs or not.  
 7 Q. You've had four or five meetings?  
 8 A. Yes.  
 9 Q. And -- and do you know whether or  
 10 not you've reviewed the insulin category?  
 11 A. No, I don't believe we reviewed  
 12 insulin.  
 13 Q. Did you review the oral  
 14 contraceptive category?  
 15 A. Let me -- let me back off a second  
 16 and here and answer --  
 17 Q. Can you just -- can you just answer?  
 18 A. The answer is no.  
 19 Q. All right. Did you review the COX  
 20 inhibitor category?  
 21 A. No.  
 22 Q. All right. And do you know whether  
 23 or not -- even though you haven't reviewed those  
 24 as somebody who's the medical director of PCN, do

1 Q. That's not my question.  
 2 A. I will just tell you what I know.  
 3 Do you want --  
 4 Q. No. I want you to answer my  
 5 question, sir.  
 6 MR. DOBIE: Would you read the  
 7 question back?  
 8 \* \* \*  
 9 (Whereupon, the requested portion of  
 10 the record was read.)  
 11 \* \* \*  
 12 A. And the short answer to that is I  
 13 don't know.  
 14 BY MR. DOBIE:  
 15 Q. So you don't know whether or not,  
 16 for example, estradiol is on the PCN formulary in  
 17 the second tier or even the first tier?  
 18 A. If you pulled the -- if you pulled  
 19 the formulary, it doesn't appear on -- on the  
 20 formulary I pulled down off the net.  
 21 Q. When did you do that, sir?  
 22 A. I pulled it down just before I came  
 23 up here.  
 24 Q. And the only product that you're

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1 you know whether or not PCN, in fact, has an  
 2 exclusive -- and by that I mean the only one  
 3 within that therapeutic category -- for either  
 4 PPIs, COX inhibitors, oral contraceptives,  
 5 estrogen replacement therapy, and insulin?  
 6 A. I will tell you on the estrogen  
 7 replacement, that on the second tier Premarin is  
 8 the -- and -- and the family of Premarin are the  
 9 drugs that are -- that are on the second tier.  
 10 Drugs like Cenestin are on the third tier.  
 11 Q. So it's your understanding that you  
 12 have an -- you have an exclusive as it relates to  
 13 Cenestin within the estrogen therapy category --  
 14 I'm sorry. Let me restate the question.  
 15 It's your -- it's your belief, sir,  
 16 that PCN has made Premarin and the Premarin family  
 17 of products an exclusive on the second tier of the  
 18 formulary since 2003?  
 19 MR. COHEN: Object -- object to the  
 20 form in terms of the use of the word  
 21 "exclusive" with respect to the second tier.  
 22 A. I do not know anything about the  
 23 contract with -- with --  
 24 BY MR. DOBIE:

1 showing on the second tier or first tier is  
 2 Premarin?  
 3 A. Is Premarin family of drugs, is as I  
 4 recall what was on the second tier.  
 5 Q. All right. And did you -- at the  
 6 time that PCN created a formulary in 2003, did  
 7 you, sir, as the head of the P&T committee decide  
 8 to make Premarin the only product in the second  
 9 tier?  
 10 A. No.  
 11 Q. Do you know who did make that  
 12 decision?  
 13 A. It was probably inherited from the  
 14 company that we had dealing with our formulary  
 15 before.  
 16 Q. The company --  
 17 A. That is PCS.  
 18 Q. AdvancePCS, sir, in 2002 had  
 19 Cenestin on their formulary and not Premarin.  
 20 A. Okay. Then I don't know.  
 21 Q. All right. You're just speculating  
 22 when you said that you think it came from the  
 23 prior company?  
 24 A. That's correct.

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1 Q. All right. So do you know who  
2 within PCN would have made the decision to put  
3 Premarin on the formulary in the second tier other  
4 than you and the other members of the P&T  
5 committee?

6 A. No, I don't. There's a lot here  
7 that I'm not telling you, but we'll leave it.

8 Q. We have a lot of questions and  
9 answers --

10 A. Yes.

11 Q. -- still to go.

12 Do you know, sir, somebody the name  
13 of Debrea Napior?

14 A. The name is familiar. Who -- could  
15 you tell me who she is so that I could try to put  
16 a name with a face?

17 Q. Does that -- you don't -- that  
18 doesn't ring a bell?

19 A. I believe I have heard "Debrea  
20 Napior," before but I don't -- I'm not putting it  
21 together with the person.

22 Q. is that -- do you know, is that  
23 somebody who -- whose article that you cited as an  
24 authoritative basis for anywhere in your report?

1 Bystrom, who indicated pretty much the same thing  
2 as Mr. Scull has.

3 Q. Okay. So you had a discussion with  
4 Mr. Bystrom. Anything else, sir?

5 A. I believe I had a discussion with  
6 some of the officers in the California Pharmacists  
7 Association, but I don't quote those as  
8 authoritative because they're not -- these --  
9 these rebate contracts aren't between the retail  
10 level and the pharmaceutical manufacturers.

11 Q. Well, there are -- there are --  
12 there are contracts between retailers and  
13 pharmaceutical manufacturers?

14 A. Yes, but not rebates generally.

15 Q. Are you familiar with pharmaceutical  
16 manufacturers and retailers actually having rebate  
17 contracts?

18 A. No. But I'm familiar with the fact  
19 that the distribution of product can go directly  
20 from the pharmacy manufacturer to the retailer.

21 Q. All right. That wasn't my question.  
22 You are -- just answer the question.

23 You are not familiar with the  
24 practice of pharmaceutical manufacturers paying

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1 Does that ring a bell?

2 A. It is, but I don't -- it doesn't  
3 jump to my mind right now.

4 Q. And to go back to the question I  
5 asked a moment ago, you -- you mentioned the  
6 Premarin situation, but do you know whether or not  
7 PCN had a single source or exclusive contract for  
8 insulin products?

9 A. No.

10 Q. You don't know?

11 A. We covered that and I didn't know.

12 Q. Okay. And you don't know as it

13 relates to PPIs or COX-2 inhibitors or oral  
14 contraceptives either?

15 A. Correct.

16 Q. Sir, other than the discussion that  
17 you had with Mr. Scull and the pharmacist whose  
18 name you can't recall who told you that exclusives  
19 are not that common within a therapeutic category,  
20 is there any other experience that you've had that  
21 allows you to provide an opinion as to whether or  
22 not exclusive or sole conjugated estrogen-language  
23 contracts is common or not within the industry?

24 A. I had the same discussion with Mr.

1 rebates to retailers?

2 A. Correct.

3 Q. Sir, given at your deposition in  
4 2002 you had no experience with these exclusive  
5 contracts, as you yourself have testified, whether  
6 it was common or not common, and you referred to  
7 others, and you've had one discussion with Mr.  
8 Scull, one discussion with this pharmacist, and a  
9 discussion with Mr. Bystrom, how is it that you  
10 think it appropriate for you to give an expert  
11 opinion to a jury as to how common exclusives are  
12 in the industry?

13 A. I am giving an opinion based upon  
14 conversations I've had with people in the industry  
15 who do this regularly.

16 Q. Okay. Those three conversations  
17 we've identified?

18 A. Yes.

19 Q. How do you know, sir -- all right.  
20 So now that you've had these three people that  
21 told you that exclusives are not that common  
22 within the therapeutic category, how then, sir,  
23 are you in a position to comment as to what impact  
24 exclusives or sole -- sole product in the

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1 therapeutic class agreements would have within the  
2 marketplace if you don't know within even your own  
3 company whether you have them or don't?

4 A. Well, those are two different  
5 issues.

6 Q. Okay. Can you -- can you -- let's  
7 go to the first issue.

8 You've told us your basis for  
9 whether you know about exclusives or not. All  
10 right. What I'm now interested in is, are you  
11 trying to give an opinion, given what I'll call  
12 the limited basis of your knowledge, on how common  
13 exclusives are? Do you actually think you have  
14 the expertise to then go the next step and give a  
15 further opinion as to how common or what the  
16 impact is of those --

17 A. Absolutely.

18 Q. -- agreements are in the  
19 marketplace?

20 A. Those are two -- two different  
21 issues. The first you're asking is my direct  
22 knowledge of the incidence of exclusive contracts,  
23 and i've given you hearsay information. The  
24 second part is my experience with what those kinds

1 in the clinical setting. Exclusive contracts  
2 would limit those.

3 Q. Okay. So exclusives would limit --  
4 when you're talking about in a clinical setting --

5 A. The drugs --

6 Q. -- you're talking about two  
7 physicians?

8 A. The drugs that are available to  
9 physicians and patients.

10 Q. All right. I understand your  
11 expertise there. All right. I'm not quarreling  
12 with you on that.

13 I mean, if what you're saying is is  
14 that you can testify as to how an exclusive would  
15 limit the options for physicians and patients,  
16 you're a physician and -- I mean, I've got your  
17 resume. I understand your expertise on that.

18 Okay. What I am talking about -- is that what you  
19 meant by your answer?

20 A. Yes.

21 Q. Okay. All right. Here's what -- is  
22 it that -- are you trying to hold yourself out,  
23 though, sir, as -- as somebody who can testify as  
24 to the impact of an exclusive, not to physicians

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1 of contracts do within the market once they're  
2 negotiated.

3 MR. DOBIE: Okay. Let's -- he's got  
4 to change the tape.

5 THE VIDEOGRAPHER: This is the end  
6 of Tape No. 2. The time is 2:59 p.m. We're  
7 off the record.

8 \* \* \*

9 (Whereupon, a discussion was held  
10 off the record.)

11 \* \* \*

12 THE VIDEOGRAPHER: This is the  
13 beginning of Tape No. 3. The time is 3:01  
14 p.m. We're back on the record.

15 BY MR. DOBIE:

16 Q. Dr. Gibson, let me ask you, if you  
17 don't know whether or not exclusive contracts are  
18 common or not, don't even know whether you have  
19 them or don't have them on the PCN formulary, how  
20 is it that you can testify as to the impact that  
21 those agreements that may or may not exist even  
22 within PCN have in the marketplace?

23 A. Testifying as to the effect in the  
24 marketplace deals with choices that are presented

1 and patients, but instead within the broader  
2 marketplace including, for example, to Duramed?

3 A. Well, it's -- as I see it, it's all  
4 pretty much the same thing. Once -- once the  
5 options are limited contractually, it has an  
6 effect in the marketplace and it has to be  
7 reflected within the clinical setting because  
8 drugs are ordered there.

9 Q. All right. Here's where I've got a  
10 disconnect I think with you.

11 How is it -- I would assume that  
12 you'd agree that there's a lot of different  
13 attributes of a product that will lead to its  
14 success in the marketplace; right?

15 A. Yes.

16 Q. A pharmaceutical product -- how  
17 many -- whether it's a breakthrough product, for  
18 example.

19 A. Correct.

20 Q. Whether it's a -- whether there's a  
21 lot of folks out detailing and explaining the  
22 product to physicians.

23 A. Correct.

24 Q. How much research that there is

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1 behind the product.

2 A. Correct.

3 Q. Those are all different things that

4 I assume that you as a physician are familiar with

5 as can impact the uptake of a product in the

6 marketplace?

7 A. Correct.

8 Q. All right. What I am -- what I'm --

9 what I'm wondering about is if you don't know in

10 any of these categories, for example, PPIs, COX

11 inhibitors, whether exclusives are or are not in

12 place at PCN or other pharmaceutical companies,

13 how is it that you can give an opinion as to

14 whether or not a product will or won't be

15 successful in the face of an exclusive?

16 A. Well, first of all, the issue of

17 anyone being able to come in and testify as to the

18 existence of exclusives without benefit of a

19 discovery process similar to what we've gone

20 through in this case couldn't testify to that.

21 I think your issue is that you're

22 having difficulty that I don't happen to know the

23 status of those drugs at PCN, which in reality if

24 you look at the landscape of the pharmaceutical

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1 market is a pretty limited footprint.

2 Q. Well, let me give you an example.

3 There are people who are hired by

4 health plans to negotiate with PBMs, the pharmacy

5 benefit, for the members of the plan; correct?

6 A. Correct.

7 Q. And people like that know, okay,

8 here's -- here is a -- the type of contract that

9 we would typically get with a -- with a particular

10 PBM and, you know, we typically see three or four

11 choices in insulin or we see one choice in PPIs.

12 There are people that are familiar with how common

13 multiple choices are within therapeutic categories

14 as a -- as a result of consulting with plans to

15 shape their -- the formulary choices of the

16 members; right?

17 A. Correct.

18 Q. You won't do that?

19 A. That's not the question you've been

20 asking me.

21 Q. Okay. All right. But if I ask --

22 Am I aware of that?

23 Q. -- you that, you don't do that?

24 A. I'm aware in general what the

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1 formularies are for the competitors to PBM and

2 whether or not there's single options within a

3 therapeutic class on the branded side. I have a

4 general feeling for that. And that's -- that's --

5 that's exactly what an officer within a HMO would

6 have. The officer in the HMO would not know if

7 these are exclusive contracts or not. Those are

8 private contracts between the PBM and the

9 manufacturer.

10 Q. You're saying that an officer of a

11 particular PBM as yourself?

12 A. I'm not an officer of a PBM.

13 Q. Let me -- well, let's not talk about

14 what other people know or don't know. Let me ask

15 you what you know.

16 Do you know, for example, whether or

17 not there are exclusives in the PPI, oral

18 contraceptives, COX inhibitors, oral

19 contraceptives, estrogen, any of the other PBMs

20 separate and apart from the work you've done?

21 A. I don't --

22 MR. COHEN: Objection. Asked and

23 answered.

24 A. I don't know and I don't think

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1 anybody else does in America other than the --

2 other than the people that actually negotiated so

3 that -- and a given PBM officer and a given

4 pharmaceutical company would know whether their

5 drug was an exclusive arrangement, but other

6 pharmaceutical companies wouldn't.

7 BY MR. DOBIE:

8 Q. Okay.

9 A. Nor would other PBMs.

10 Q. But somebody consulting for a -- for

11 a health plan would know whether or not -- if they

12 go to Express Scripts, if they go to PCN, if they

13 go to Medco, whether or not they're -- what kind

14 of choices they're being offered?

15 A. They'd know what choices.

16 Q. And they --

17 A. They wouldn't know if -- the terms

18 of the contracts they had with the manufacturers,

19 nor would they know if they were exclusives.

20 Q. Let me finish. Wouldn't they know

21 whether or not they were being offered a health

22 plan for their members that had more than one

23 product on formulary?

24 A. They would know what the

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1       formulary -- they would know what the health  
2       plan's formulary is.  
3           Q.       All right. And --  
4           A.       I mean the PBM's formulary.  
5           Q.       Okay. And they would know whether  
6       or not the PBM was listing one product in the PPI  
7       category or three; correct?  
8           A.       Correct.  
9           Q.       And they would know whether or not  
10       there was one product or three in the COX  
11       category?  
12          A.       Correct.  
13          Q.       Same thing. One or three in the  
14       oral contraceptives.  
15                I mean, we could go through the  
16       whole list. They would know that much; right?  
17          A.       They would.  
18          Q.       And they would also know whether or  
19       not -- if they asked, whether or not there were  
20       rebate dollars that were going to be passed down  
21       to them; correct?  
22          A.       Correct. But -- but what you're  
23       asking is is there an expert who could tell you  
24       what the contractual relationships are for

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1       exclusive relationships across the industry, and I  
2       would argue that nobody knows that.  
3           Q.       Right.  
4           A.       I mean, those are all proprietary  
5       agreements.  
6           Q.       All right. But going back to the  
7       example that -- that I gave, you're not in the  
8       position -- you're not in the position, though, of  
9       somebody like what I described before, who advises  
10       the plan and can tell them what they're going to  
11       get -- you're going to get, you know, one of one  
12       insulin at -- with Express Scripts. You're going  
13       to get -- you're going to get two COX products at  
14       Medco. You're not a person that engages in that  
15       type of a consulting practice; right?  
16          A.       I'll give you -- that I do, but it's  
17       not exactly as we've discussed up till this point.  
18                Within the context of the data  
19       mining that I do, I know -- I know who the PBMs  
20       are for the plan and I know all the drugs that  
21       have been dispensed. So I know exactly what's on  
22       their formularies and what are coming out as  
23       dispensed items.  
24          Q.       Those are the --

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1           A.       I don't know anything about the  
2       underlying contractual relationships.  
3           Q.       Okay. But again, you've had two  
4       projects as it relates to that; correct?  
5           A.       No. But you asked whether or not in  
6       the course of my regular activities, if I would  
7       have access to that kind of information, and I  
8       would -- I'm giving you an instance where I do.  
9           Q.       Okay. In those two instances, you  
10       know whether or not they typically prescribe  
11       multiple or only one product within the  
12       therapeutic class?  
13          A.       I know by class every drug that was  
14       dispensed.  
15          Q.       That's all on a -- on a -- in  
16       documents that you have?  
17          A.       It's on the -- it's on the pharmacy  
18       claims data --  
19          Q.       All right.  
20          A.       -- that goes into the data  
21       warehouse.  
22          Q.       Have you made any study, sir, that  
23       examined how many products within a particular  
24       therapeutic category the members are -- are being

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1       prescribed for either of the two plans where  
2       you've undertaken that process?  
3           A.       Yes, I did on both.  
4           Q.       You did.  
5           A.       And --  
6           Q.       And with both categories, did you --  
7       with both of those two clients, did you -- did you  
8       make any investigation in terms of whether or not  
9       any of the products were prescribed pursuant to  
10       prior authorization?  
11          A.       No.  
12          Q.       Did you make any examination in  
13       terms of whether or not the products were either  
14       in a first, a second, or a third tier?  
15          A.       No. I knew what was dispensed and  
16       what was -- and what was paid.  
17          Q.       All right. And this report that  
18       you're talking about, did you -- did you provide  
19       that to the folks that -- that hired you in  
20       connection with this --  
21          A.       No.  
22          Q.       -- project? Do you have that report  
23       today?  
24          A.       No.

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1 Q. Why did you prepare the report?  
2 A. I prepared the report about four  
3 weeks ago.  
4 Q. Okay. On your computer?  
5 A. Uh-huh.  
6 Q. Which one?  
7 A. The one in my home office, the  
8 desktop.  
9 Q. Did you retain it?  
10 A. I have it, yes. The one --  
11 Q. And are you --  
12 A. -- problem here within --  
13 Q. Let me -- let me ask you this: Are  
14 you relying upon that data or information as part  
15 of the conclusions and opinions that are -- you  
16 are offering here today?  
17 A. It would only be tangentially. The  
18 issue came up in the context of the question you  
19 asked.  
20 Q. Okay. But you're -- you're telling  
21 us that you are now -- well, I was asking you,  
22 sir, about your experience with negotiating  
23 contracts and whether or not you can give an  
24 opinion as to the impact in the marketplace of

1 I'm not confident that I can give you that  
2 information. I'll be happy to do it if there's  
3 not a -- if there's not a problem with it, and I  
4 will check on it. But certainly giving you a copy  
5 of a report with patient names on it, I could not  
6 do that.  
7 Q. You could delete the patient names.  
8 What I'm -- what I'm trying to  
9 understand, sir, is in this instance, as you just  
10 described, if you don't know whether or not any of  
11 the products that were dispensed were prior  
12 authorized first, second, or third tier, what the  
13 formularies were or weren't for either of those  
14 plans, how is it that you can rely upon -- or are  
15 you relying upon that work in forming your  
16 opinions as --  
17 A. No.  
18 Q. Okay.  
19 A. I'm not -- I'm not relying on it,  
20 but that was not what I was -- that wasn't the  
21 question I was answering.  
22 Q. Well, we misunderstood each other  
23 then.  
24 So -- so then in terms of your --

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1 exclusives.  
2 A. If I recall the question I was  
3 answering, you were asking whether or not as an  
4 individual involved with the industry, whether I  
5 would know, like others do, whether health plans  
6 had multiple options within class. And I was  
7 being responsive in answering that I do have  
8 access to that information, though it's not a  
9 major part of my practice yet.  
10 Q. Did you make an examination as to  
11 whether any of the products that are -- that you  
12 reviewed were either on formulary or off  
13 formulary?  
14 A. No. I made a -- I made -- I have  
15 access to outcomes, what were actually dispensed.  
16 Q. As it relates to these -- these --  
17 tell me the names of the two -- two groups for  
18 whom you prepared this report.  
19 A. I'm not sure I'm prepared to give  
20 you those names, given the fact that this is under  
21 HIPAA.  
22 Q. I'm not asking for patient  
23 information.  
24 A. I know, but even the clients' names,

1 your experience and the ability to testify as to  
2 what impact exclusives or sole contracts within a  
3 therapeutic category have in the marketplace,  
4 being on formulary or off formulary, if you  
5 haven't -- and you don't know which products are  
6 or aren't in exclusive position, how can you give  
7 an opinion as to the impact of those exclusives,  
8 what that would have in the marketplace beyond the  
9 physician-patient realm?  
10 A. Well, the major access I have that  
11 gives me authority in this instance is the  
12 documents supplied by Wyeth in discovery.  
13 Q. All right.  
14 A. Based on that, I know what contracts  
15 were exclusive with the various MC -- MCOs that  
16 had captive PBMs and the various PBMs in the  
17 marketplace, the major PBMs that have footprints  
18 in the market.  
19 The reason I don't know the data  
20 relating to PCN is it's a fairly marginal player.  
21 So I didn't have access to PCN documents to be  
22 able to review, but it's that information which  
23 gives me the ability to comment on contracts and  
24 their effects.

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1 Q. I just want to make sure I  
2 understand that.  
3 So -- so the -- we've identified now  
4 your discussion with Mr. Scull, the discussion  
5 with the pharmacist, the discussion with Mr.  
6 Bystrom, and now you're saying that you've had  
7 access to the documents in this case?  
8 A. Correct.  
9 Q. All right. Is there anything else  
10 that you can think of that gives you a basis to  
11 form your opinion as to what effect an exclusive  
12 contract has in the marketplace separate and apart  
13 from how it may impact on patients and physicians  
14 if the formulary is limited?  
15 A. In addition to the issues that I've  
16 given to you, the conversations and the --  
17 Q. Yes, sir.  
18 A. -- contracts and all the rest is the  
19 authoritative sources that I've quoted in my  
20 report and footnoted.  
21 Q. Okay. Anything else?  
22 A. That would be it. And allow -- let  
23 me put in. And general reading that I did not  
24 put in the report or -- or footnote.

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1 Q. Well, if there's anything else that  
2 forms the basis for your opinions, I'm entitled to  
3 have that. So can you identify any other general  
4 reading that forms the basis for your opinions?  
5 A. I read all the time. I read both  
6 the professional and the lay literature all the  
7 time. If it didn't rise to the level of being  
8 critical for this report, I didn't include it nor  
9 footnote it.  
10 Q. All right.  
11 A. But I read generally constantly. So  
12 I can't, you know -- I read five newspapers every  
13 day and read most of the medical journals.  
14 Q. All right. Well, if -- the way that  
15 the rules work and the way -- in terms of both  
16 side is if there's some other source that forms  
17 the basis for your opinions, I'm entitled to know  
18 what it is, I'm entitled to review it and see  
19 whether or not there's something in there that I  
20 might ask you about to test the basis, the  
21 foundation for your conclusions.  
22 A. Well, fair enough.  
23 Q. So --  
24 A. And I -- within the context of the

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1 rules and the fairness issue, what I have written  
2 and what I have footnoted is the basis on which  
3 I'm forming my opinions.  
4 Q. Okay. Fair enough. All right.  
5 Let me ask you about another area  
6 that was previously covered by Mr. Bystrom, and  
7 that relates to the pharmacy side. And in your  
8 last deposition, I asked you if you knew how it  
9 worked between -- if a -- if products were on a  
10 third tier, whether or not they'd be -- whether  
11 they would be prescribed or -- strike the  
12 question.  
13 I asked you in your last deposition  
14 if you knew if a patient walked into a pharmacy  
15 and had a product on the third tier, for example,  
16 Cenestin -- say Cenestin was on the third tier --  
17 whether you knew whether the pharmacist would  
18 dispense the product and charge them a cash price,  
19 a third-tier copay, or something else, and you  
20 deferred to Mr. -- Mr. Bystrom on questions like  
21 that, including that question.  
22 Have you done anything on the work  
23 side that now has educated you in terms of how  
24 that process works in the marketplace?

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1 A. "The work side" being the real world  
2 or was that --  
3 Q. Separate and apart from litigation.  
4 A. Okay. Yes, I have. In my  
5 activities with pharmacists across the state of  
6 California, I will frequently ask them informally  
7 how they handle this situation. Do they -- do  
8 they charge the copay if it's higher than the  
9 acquisition cost or do they go with the lower of  
10 the two.  
11 Q. All right. So let me --  
12 A. Is that the question you're asking?  
13 Q. Yes. Let me give you -- let me give  
14 you a hypothetical. All right.  
15 If the cash price for Cenestin --  
16 and you can write this down -- was, let's say,  
17 \$27.  
18 A. Okay.  
19 Q. And the negotiated --  
20 A. I'm not supposed to write on any of  
21 this stuff, am I?  
22 Q. Try writing on there.  
23 A. Thanks.  
24 Q. If the cash price for Cenestin is,

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1 let's say, \$27 --

2 MR. COHEN: Cenestin?

3 MR. DOBIE: Yes, Cenestin.

4 MR. COHEN: Not Premarin. Okay.

5 BY MR. DOBIE:

6 Q. Cenestin is \$27. It's on -- the

7 patient has a health plan that puts Cenestin on

8 the third tier, so that it's at \$30 copay. that

9 would be the second choice. Or would the patient

10 be charged the negotiated price between their --

11 their pharmacy benefit manager and the retailer?

12 Let's say the negotiated price was an AWP on

13 Cenestin, \$25, minus 10 percent, plus a -- which

14 would take it down to 22.50 plus a \$2 handling

15 fee. So that's 24.50.

16 Would they get charged the 24.50,

17 the negotiated price, in essence, would they get

18 charged the cash price of \$27, or would they get

19 charged the copay for a third-tier product, again

20 assuming that the plan had put Cenestin in the

21 third tier of \$30?

22 MR. COHEN: So your hypothetical

23 is -- is not zeroing on in any particular

24 pharmacy chain, any particular type of

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1 pharmacy?

2 MR. DOBIE: No.

3 MR. COHEN: Just broadly --

4 MR. DOBIE: Just --

5 MR. COHEN: -- any pharmacy?

6 MR. DOBIE: -- his experience, his

7 understanding of how it works.

8 A. You've got several things in that

9 question.

10 BY MR. DOBIE:

11 Q. Okay.

12 A. Okay. First of all, you would not

13 normally pass on to the patient the dispensing fee

14 that you negotiated with the PBM. You know, you

15 went from the \$24 and added 2.50. So --

16 Q. Nor would -- the patient wouldn't --

17 they wouldn't pay that --

18 A. The patient would normally also pay

19 2.50 if they'd been paid 2.50 for a dispensing fee

20 by the PBM.

21 Q. So a pharmacist wouldn't normally

22 charge them the negotiated price in my example of

23 25 minus --

24 A. I haven't gotten to that part yet.

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1 Q. Okay.

2 A. I was just zeroing in on the

3 dispensing fee and whether or not in your

4 hypothetical it would be passed on to the patient.

5 Q. The charge?

6 A. Yes.

7 Q. You don't think so?

8 A. Well, the charge -- the 2.50 has

9 already been paid by the PBM to the pharmacy as a

10 dispensing fee.

11 Q. I'm -- here -- let me make sure

12 you're clear on the hypothetical.

13 Okay. This is a situation where --

14 where the patient has a Cenestin script. It's on

15 the third tier because the plan has put it on the

16 third tier.

17 A. Correct. I'm with you there.

18 Q. Okay. So that we got the \$30.

19 A. You got the \$30.

20 Q. You got the \$25 you walk in off the

21 street. And then the last option is that there's

22 actually a negotiated price between the PBM and

23 the retailer where they have an AWP price, average

24 wholesale price, of \$25 minus 10 percent, which is

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1 the 22.50, but then they charge a \$2 handling fee

2 or service fee on top of that. 24.50.

3 A. Okay. I'm -- I'm admittedly

4 focusing on part of your answer, not the whole one

5 here, and that's that 2.50 issue.

6 Q. You don't think they'd be charged

7 that at all?

8 A. They'd never be charged that.

9 Q. Because the -- because the PBM would

10 pay that?

11 A. It's already paid.

12 Q. All right. So would the patient --

13 A. So the question boils down to would

14 they be charged the negotiated fee or the copay,

15 whichever --

16 Q. Or the cash price.

17 Q. -- is the greater. Or the third

18 option would be the cash price.

19 Q. Right.

20 A. The --

21 MR. COHEN: Could I just -- does the

22 patient that walks in have insurance or not?

23 MR. DOBIE: This is -- this is

24 the -- I don't know if "insurance" is the

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1 right word, Jay, but it's a -- the plan has  
2 got a third-tier copay. That's --  
3 MR. COHEN: This is not a cash-  
4 paying customer. It's a customer who has a  
5 plan?

6 MR. DOBIE: Yes.

7 MR. COHEN: Correct?

8 MR. DOBIE: Yes.

9 A. There are no absolutes and  
10 furthermore, there's no, to my knowledge,  
11 published material to give you a footnote on this.

12 In general, the pharmacists charge  
13 the greater of, the greater of the copay or the  
14 acquisition -- well, they can't charge beyond the  
15 copay. But if the copay is greater, they'll  
16 charge the copay. That's consistent with their  
17 behavior across the board for both brand and  
18 generic products.

19 And though we won't go into it  
20 unless you want to, the issue of how generics are  
21 charged within the market, particularly the mail  
22 order environment, is -- is overwhelmingly they're  
23 charging the copay amount.

24 BY MR. DOBIE:

1 you this? Can you name one?

2 A. When I visited with people like  
3 Walter Carey, who is president of a not-for-profit  
4 in southern California that's affiliated with  
5 UPNI, that was the feedback I would get.

6 Q. When did you --

7 A. I talked this over with a number of  
8 the board members from California Pharmacists  
9 Association, all of whom are practicing  
10 pharmacists.

11 And to buttress it, the issue of the  
12 literature, there was not more than a month ago a  
13 major article in the Wall Street Journal dealing  
14 with dispensing practices for generic drugs and  
15 the pricing of the transaction.

16 Q. What did the -- what do you recall  
17 about the Wall Street Journal article?

18 A. Wall Street Journal article  
19 demonstrated how the dispensing of generics is the  
20 highest profit margin within the system. It's a  
21 major reason why PBMs with mail orders are moving  
22 the dispensing of those products to the mail order  
23 pharmacy. And the example they gave was for  
24 generic Prozac.

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1 Q. Okay. What's the basis for your  
2 conclusion, sir, that -- that the pharmacists  
3 would charge the greater of the copay or -- versus  
4 either the cash price or the negotiated price?

5 A. You -- you --

6 Q. How do you know that? You didn't  
7 know that --

8 A. At the --

9 Q. -- in your last deposition?

10 A. Between my last deposition and now,  
11 I've had a lot more conversations with pharmacists  
12 who are actually dispensing product.

13 Q. In California?

14 A. Mostly in California, not all, but  
15 mostly in California, Oregon, Washington, and  
16 Kentucky.

17 Q. And they've told you that it's their  
18 usual practice in these pharmacies that if their  
19 cash price is -- is, let's say, \$25, they  
20 nevertheless go ahead and charge a higher copay  
21 amount?

22 A. Absolutely. And --

23 Q. Who are the -- who are the  
24 pharmacists that you've talked to that have told

1 Q. So the PBMs make more money on  
2 generics than on branded products?

3 A. They do now.

4 Q. Do -- do the dispensing pharmacists  
5 make more money on generics?

6 A. They do now. They always have.  
7 Generics have always been more profitable than  
8 brand for -- in a managed care environment for a  
9 dispensing pharmacist.

10 Q. Who are the board members of the  
11 California Pharmacists Association that told you  
12 that they charge higher of the copay or the cash  
13 amount?

14 A. I don't -- I don't -- I'm sorry, but  
15 I'm not going to give you the names of the whole  
16 California Pharmacists board. I visited with  
17 people at various times. I've had this  
18 conversation. This is the feedback I've gotten.  
19 But I'm not prepared to put quotation marks around  
20 it and give you a footnote.

21 Q. Well, we're entitled to know the  
22 basis for your opinion, sir, and if there's  
23 somebody who told you this -- you didn't have this  
24 expertise. They had another expert, Mr. Bystrom.

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1 Okay?

2 A. Right.

3 Q. Now you've got that expertise,

4 you're telling us, and you want to tell the jury,

5 right, and so I'm entitled to know the basis for

6 that opinion that you want to offer.

7 A. But what I'm telling you is I've

8 these conversations with these people and this is

9 the feedback I've gotten back, but I'm not

10 prepared to say that -- exactly which one of the

11 board members I had the conversation with and got

12 it back from.

13 Q. Okay. And I understand that you

14 would rather not say, but I'm entitled to know

15 that information.

16 MR. COHEN: I'm just going to object

17 to -- and I'm not trying to characterize his

18 testimony, but it seemed to me he was

19 saying -- he was really saying he doesn't

20 recall which of these people it was rather

21 than he's withholding a name.

22 And if I'm wrong about that, he can

23 correct me.

24 THE WITNESS: Well, that's -- that's

1 knowledgeable in the industry like John Scull.

2 And I visited on several occasions with Dale

3 Bystrom.

4 Q. Mr. Scull tell you that the practice

5 to his understanding was to charge for pharmacy --

6 A. It was his understanding that in

7 general --

8 Q. Can I finish the question?

9 That generally speaking, pharmacies

10 charge the higher of the copay or cash amount?

11 A. Correct.

12 Q. Other than having discussions with

13 these individuals where they've -- where they've

14 told you this, do you have any other basis to

15 offer an opinion as to how it would work in the

16 pharmacy side?

17 A. I think that that and -- and based

18 on reading, that would be the two sources.

19 Q. Okay. And the reading is the Wall

20 Street Journal article. Anything else?

21 A. That's -- that would be the major

22 article.

23 MR. COHEN: Gordon, are you at a

24 good break point?

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1 really correct.

2 MR. DOBIE: Thanks for that --

3 thanks for that hint, Jay.

4 BY MR. DOBIE:

5 Q. So rather than you not being

6 prepared to tell me who it is, now you don't

7 recall who it is?

8 A. This has come up in the context of

9 your question.

10 Q. Yes.

11 A. And I don't recall exactly who gave

12 me the information. I generally know who I talked

13 to about it.

14 Q. Okay. Who generally do you know

15 that you talked to about this?

16 A. I talked -- as I mentioned, Walter

17 Carey.

18 Q. Yes.

19 A. David Brazelton, who -- who is the

20 head of UPNI and also on the board of CPHA. I

21 visited with a board member from Bakersfield,

22 Clark Gustafson.

23 Q. Anyone else?

24 A. And again, I visited with people

1 MR. DOBIE: Sure.

2 MR. COHEN: Thanks.

3 THE VIDEOGRAPHER: We're going off

4 the record. The time is 3:34 p.m.

5 \* \* \*

6 (Whereupon, a short recess was

7 taken.)

8 \* \* \*

9 THE VIDEOGRAPHER: We're back on the

10 record. The time is 3:47 p.m.

11 BY MR. DOBIE:

12 Q. Sir, you mentioned the fact that you

13 discussed with Mr. Bystrom what was the process by

14 which it usually worked. Do you recall that

15 testimony from a moment ago?

16 A. I do.

17 Q. And what did Mr. Bystrom tell you?

18 A. As I recall, he was consistent with

19 what I have testified, that in the hypothetical

20 you are -- you are presenting, that the retail

21 pharmacy would charge the copay.

22 Q. The higher copay?

23 A. Yes.

24 Q. All right.

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1 A. He also said one other thing that  
2 was interesting, too, as I recall. It was either  
3 he or John Scull. That it really isn't important  
4 what the -- what the retail rate was versus the  
5 third tier in particularly your hypothetical. The  
6 real important thing is the difference between the  
7 second-tier copay and either the retail or the  
8 copay amount for the third tier.

9 So if -- if you have a second-tier  
10 product in class sitting there at a \$20 copay and  
11 you have either a 27 or a 30 dollar copay, you're  
12 still dealing with a significant delta or  
13 difference.

14 Q. And if it's a \$5 copay difference?

15 A. Well, you've got data that I quoted  
16 in here from your own internal sources as to the  
17 importance of brand seepage based upon the amount  
18 of copay that is in the market.

19 Q. No. I'm talking about your  
20 discussion with Mr. Bystrom or Mr. Scull.

21 A. Oh. We didn't get to --

22 Q. You didn't get to that --

23 A. -- that level of detail.

24 Q. They just said that the bigger the

1 could turn your attention -- I'm sorry, Mr.  
2 Bystrom's deposition -- to Line --Page 57 -- I'm  
3 sorry, Page 56, Line 23. He's asked -- Mr.  
4 Bystrom is asked the question, "but they often --  
5 in fact, almost always, negotiate special prices,  
6 special negotiated prices; right?

7 "ANSWER: Prices that managed care  
8 negotiates with retail pharmacy providers has  
9 normally several levels involved in it. It's  
10 usually a negotiated discount off the cost of the  
11 medication plus a dispensing fee or a maximum  
12 allowable cost called MAC or usual and customary,  
13 and it defaults to whatever is the lesser of the  
14 three. So in some cases, it's possible that a  
15 managed care patient would pay usual and retail,  
16 usual and customary retail," period.

17 Do you see that?

18 A. I do.

19 Q. Okay. Do you see here where Mr.  
20 Bystrom is actually saying it's the lesser of the  
21 three, not the higher of the three, which is your  
22 testimony?

23 A. We're mixing apples and oranges  
24 again. MAC pricing relates to generics, not

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1 difference in copay, the more significant --

2 A. Sure.

3 Q. -- that second versus third --

4 A. Absolutely,

5 Q. -- tier would be?

6 Q. Dr. Gibson, if you let me finish the  
7 question. Otherwise, we're going to have a pretty  
8 confused record here.

9 What the question was is what you  
10 heard from Mr. Scull or what you heard from Mr.  
11 Bystrom was that the most important thing was --  
12 I'm not talking about what's in the documents.  
13 I'm talking about what they told you -- was the  
14 amount of the difference between the second- and  
15 the third-tier copay.

16 A. And what I said was the difference  
17 between the second and third tier or the second  
18 and the retail price.

19 Q. Right.

20 A. That was the point I was trying to  
21 make.

22 Q. Understood. Sir, let me show you  
23 what was previously marked today as Exhibit 6.

24 This is Mr. Gibson's deposition. And sir, if I

1 brand.

2 Q. I understand that. He's -- but he's  
3 saying that it defaults to the lesser of the  
4 three, whether it's a negotiated discount off the  
5 cost of the medication plus a dispensing fee or a  
6 maximum allowable cost -- the first part relates  
7 to the generic -- I'm sorry, relates to the brand.  
8 The second one is how it works on a generic or  
9 usual or customary and defaults to whatever is the  
10 lesser of the three.

11 Does that refresh your recollection,  
12 sir, as to what Mr. Bystrom may have told you?

13 A. It didn't come up in this context  
14 and that was not the answer I recall --

15 Q. All right. Well, let me --

16 A. -- I asked.

17 MR. COHEN: I'd just like to  
18 interpose an objection. It appears that  
19 this -- that he's -- he's testifying about  
20 what managed care negotiates with retail  
21 pharmacies, not what somebody off the street  
22 would pay.

23 THE WITNESS: Right.

24 MR. DOBIE: No. He says it's the

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1 patient. We're talking -- Jay, your  
2 example --  
3 BY MR. DOBIE:  
4 Q. What you said to me was is this  
5 somebody who has -- your -- your refinement on the  
6 hypothetical, is this somebody who has the  
7 benefits.  
8 A. No. But what his answer is is the  
9 price that managed care negotiates with the retail  
10 pharmacy is the lesser of the three.  
11 Q. The managed care patient would pay  
12 is usual and retail. All right. Let's -- let's  
13 try --  
14 A. Did it say that? Where does it say  
15 that?  
16 Q. The very last line, sir.  
17 Let me show -- let me show you  
18 another document and let's -- we can move on.  
19 A. But it doesn't say in that sentence  
20 what you alleged it to say. It says that "So in  
21 some cases, it's possible that a managed care  
22 patient would pay usual and retail or usual and  
23 customary retail."  
24 Q. Right. The lesser of the three.

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1 A. It doesn't say three. It says two.  
2 \* \* \*  
3 (Whereupon, Gibson Exhibit 11 was  
4 marked for identification.)  
5 \* \* \*  
6 BY MR. DOBIE:  
7 Q. The document speaks for itself.  
8 Let me show you a document, sir that  
9 you haven't mentioned as having been identified,  
10 so it may be the first time you're seeing it.  
11 For the record, Exhibit 11 is a copy  
12 of a document that was produced by -- by Duramed  
13 in this case. Have you ever seen this document  
14 before?  
15 A. Not to my recollection, no.  
16 Q. Okay. This is a document that was  
17 identified as having been prepared by the folks  
18 that were involved in the managed care group at  
19 Duramed, and they have an example here of how a  
20 Cenestin script would be paid at retail, and if  
21 you look underneath the graph in the center of the  
22 page, it says, "In the above example, the actual  
23 cost of Cenestin to patient equals 15.74, since  
24 this is the amount" -- "since this amount is less

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1 than the \$25 copay for nonformulary products."  
2 Were you aware, sir, that it was  
3 Duramed's understanding of the marketplace that,  
4 in fact, patients would, in fact, pay the lesser  
5 of the cash price or the negotiated price as  
6 opposed to the higher third-tier or nonformulary  
7 branded product price?  
8 A. I had not seen this document before.  
9 I'm not sure that that's what they're alleging is  
10 that's the way the market works. They're making  
11 an artificial hypothetical as to how they price  
12 their product and what it would cost if they were  
13 charged -- if they were charging the retail on it.  
14 Q. Did you read Mr. Finneran's  
15 deposition, for example, from Viking?  
16 A. No.  
17 Q. All right. Did you read Marty  
18 Carter, the head of managed care's, deposition  
19 from Duramed?  
20 A. No.  
21 Q. So did you know what the -- what  
22 their view is in terms of what they saw in the  
23 actual marketplace, whether -- how Cenestin was  
24 handled, whether it would be charged or whether

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1 it, in fact, was -- was the charge that a patient  
2 would pay if they had a Cenestin script, whether  
3 they would actually be charged the lesser of the  
4 \$25 copay or the negotiated price for the cash  
5 price?  
6 A. No. Until this conversation, I  
7 didn't know their position.  
8 \* \* \*  
9 (Whereupon, Gibson Exhibit 12 was  
10 marked for identification.)  
11 \* \* \*  
12 BY MR. DOBIE:  
13 Q. Sir, I'm handing you what's Exhibit  
14 12.  
15 For the record, Exhibit 12 is a copy  
16 of a document prepared for the California Health  
17 Care foundation by Mercer Human Resources  
18 Consulting. We pulled this off the Web as well.  
19 Mercer, sir, is a -- is a group you  
20 mentioned many times in your first deposition.  
21 You recall that?  
22 A. I do.  
23 Q. This is a group that advises health  
24 plans in terms of how to go about buying a

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1 prescription drug benefit?

2 A. Right. Their primary -- their

3 primary consulting practice is with the buyer.

4 Q. The buyer being a health plan?

5 A. Well -- or the employer. They're

6 employee benefits consulting specialists.

7 Q. So if -- so if I'm an employer and I

8 want to buy basically health insurance or self-

9 insure, I might go to Mercer for advice on how to

10 do that?

11 A. Uh-huh.

12 Q. And is this a group that has

13 expertise in your view in terms of how common

14 different types of arrangements are, rebate

15 contracts, exclusives, things like that?

16 A. I think they would be knowledgeable,

17 yes.

18 Q. Do they have a database that has

19 information like that?

20 A. I don't know.

21 Q. There's a -- let me draw your

22 attention to -- have you ever seen this document

23 before?

24 A. I don't recall that I have. I've

1 disagreeing with -- with the statements by Mercer

2 in this report to the California Health Care

3 Foundation?

4 A. No.

5 Q. All right.

6 A. Are we done with this?

7 Q. Yes, sir, for the moment.

8 Let me ask you about your experience

9 with pharmaceutical marketing. You have never

10 marketed pharmaceutical product; correct?

11 A. Correct.

12 Q. And again, you've never worked for a

13 pharmaceutical manufacturer, served on an advisory

14 committee as it related to any issue whatsoever;

15 correct?

16 A. Correct.

17 Q. And you've never taught

18 pharmaceutical marketing?

19 A. No.

20 Q. Have you ever written any articles

21 on pharmaceutical marketing?

22 A. I have written articles with issues

23 of pharmaceutical marketing within them.

24 Q. And which of the articles that are

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1 seen a number of California Health Care Foundation

2 documents, but I don't believe I've seen this one.

3 Q. Let me draw your attention to Page

4 15. There -- there's a discussion about usual and

5 customary retail pricing.

6 A. My document only goes up to 9.

7 Q. It's in the lower right-hand corner.

8 A. Still going here.

9 Here we go. It starts at the top

10 with contracts between PBM and health plans?

11 Q. Yes, sir.

12 A. Okay.

13 Q. And over on the right under "Usual

14 and customary" --

15 A. Yes.

16 Q. All right. And the second sentence

17 says, "When the usual and customary retail price

18 is higher than the contracted price, the PBM pays

19 only the contracted price. When the usual and

20 customary retail price is lower than the

21 contracted price, the PBM pays the usual and

22 customary price." Do you see that?

23 A. I do.

24 Q. Do you have any basis for

1 attached to your report have pharmaceutical

2 marketing issues within them?

3 A. As I recall, the article that I

4 wrote concerning the diminishing pharmacy benefit

5 contained issues of marketing.

6 Q. This is the "Consumers can look

7 forward to deductibles, generic drugs, and online

8 Canadian purchases"?

9 A. No. That is -- that was my article

10 dealing with why pharmaceuticals are cheaper in

11 Canada, I believe, that -- that you're looking in

12 Organized Labor?

13 Q. No. I was looking at your list of

14 articles here, "The Diminishing Pharmacy Benefit."

15 A. Let's see. This was on -- yes, that

16 was it.

17 Q. That is the article?

18 A. I think there was a tangential

19 discussion about pharmaceutical marketing in that.

20 And let's see. I'm not sure if the article

21 dealing with "What Comes after Managed Care" had

22 pharmaceutical issues. It dealt mostly with

23 managed care and HMOs. I think those are probably

24 the articles that might have some information

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1 about pharmaceutical manufacturer marketing.  
2 Q. Okay. And does -- does the  
3 preparation of either two -- those two articles in  
4 your view make you an expert to give an opinion on  
5 pharmaceutical marketing to a jury in this case?  
6 A. I know -- I know how pharmaceutical  
7 marketing works, but I'm not -- I'll leave it to  
8 others as to whether I'm the expert or not.  
9 Q. Okay. Well, do you -- do you  
10 yourself view yourself as --  
11 A. I think I'm knowledgeable.  
12 Q. If I could finish the question.  
13 Do you view yourself as an expert in  
14 pharmaceutical marketing, having written two  
15 articles, one of which has a a tangential mention  
16 of marketing, to use your terms?  
17 A. Again, that wouldn't be the only  
18 reason I would claim to be an expert or giving an  
19 opinion.  
20 The involvement in the market on a  
21 daily basis, conversations both with the  
22 prescribing physicians and the dispensing  
23 physicians, and an overall reading knowledge of  
24 how the market works would be the pillars on which

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1 I would render opinions.  
2 Q. Okay. And what I'm asking is is  
3 whether that, talking to physicians and patients  
4 and having written these two articles -- whether  
5 you believe that that qualifies you to give an  
6 opinion as to pharmaceutical marketing as an  
7 expert.  
8 A. Okay. That's a new question. The  
9 answer is yes. That wasn't the one you asked  
10 before.  
11 Q. And why -- why do you think that you  
12 are an expert in pharmaceutical marketing based on  
13 your experience?  
14 A. Because as with all the other issues  
15 we've been discussing today, I have a much more  
16 broad view of how the mosaic works. I have never  
17 claimed to have negotiated a rebate contract or  
18 marketed a drug or any of the other issues we've  
19 talked about. I do have the overview of how the  
20 market works and understand marketing's role in  
21 that.  
22 Q. Is any -- is anybody -- well, strike  
23 that.  
24 Is your expertise in pharmaceutical

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1 marketing -- strike that.  
2 Isn't it true, sir, that in this  
3 case, when you looked at the Premarin preemptive  
4 plan, which is a marketing document, you didn't  
5 even understand it and had to talk to Mr. Bystrom,  
6 who does have more experience, about it?  
7 A. No, that's not correct at all. When  
8 we both first looked at it, neither of us  
9 understood it. We took -- it took us time to be  
10 able to really study that document to understand  
11 what all was in it. By the time we were finished,  
12 we both understood it.  
13 Q. And -- and having read it, then you  
14 understood the -- in your view what Wyeth's  
15 marketing plan was as it related to Premarin and  
16 Cenestin?  
17 A. I understood the Premarin preemptive  
18 plan. I don't know that I understood their entire  
19 marketing strategy, but I knew how they were using  
20 the various legs of the Premarin preemptive plan  
21 and how they were both rewarding and punishing  
22 people who behaved in fashions that were not  
23 consistent with what they wanted.  
24 Q. Is -- is that -- that review of the

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1 document that you made, is that -- is that  
2 something that if -- that if you showed it to a  
3 member of the jury, they could understand that as  
4 well, or Mr. Cohen?  
5 A. I think I could show exhibits to the  
6 jury so they'd understand. Is that your question?  
7 Q. No. It's a different question.  
8 This -- this view that you have that  
9 the -- well, strike that. Strike that.  
10 Is there any other marketing,  
11 pharmaceutical, or any other background that you  
12 have, sir, that qualifies you to give an expert  
13 opinion on pharmaceutical marketing that we  
14 haven't talked about?  
15 A. We've been at this for several hours  
16 now. I think we've pretty well covered it.  
17 Q. No. I'm talking about just as it  
18 relates to pharmaceutical marketing, which we've  
19 only been on for 10 minutes.  
20 A. I think -- I think my most detailed  
21 view of -- of how marketing really works in the  
22 pharmaceutical sector was through the discovery  
23 documents within this case.  
24 Q. Okay. Let's talk about the P&T

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1 committee. We covered already your experience at  
2 PCN with the P&T committee in some detail. We  
3 covered briefly in your last deposition Omni, and  
4 am I right that Omni simply had a -- had a  
5 formulary that -- it was a -- it was a formulary  
6 that you obtained from Integrated through PCN?

7 A. Correct.

8 Q. And it was essentially a two-tier  
9 formulary?

10 A. As I recall, it was two-tier.

11 Q. And do you know whether or not  
12 products that were not in the second tier --  
13 strike that.

14 There's -- there's different ways to  
15 have a two-tier formulary; right? You can have  
16 branded and generic. You can branded, generic,  
17 and then not covered. Do you know how it worked  
18 at PCN?

19 A. It was primarily generic versus  
20 brand. The only reason you would slip a brand  
21 into the first tier was if it was unique in class.

22 Q. So basically patients would pay a  
23 lower copay for any branded pharmaceutical at PCN;  
24 is that correct?

1 Q. All right.

2 A. Without a prior authorization.

3 Q. And how often did the P&T committee  
4 of Omni meet?

5 A. It was fairly infrequent. As I  
6 recall, it was like once every six months.

7 Q. All right. And you were there 18  
8 months, so maybe three meetings?

9 A. A couple of years. What are the  
10 dates?

11 Q. We went through that at the  
12 beginning. I think it was --

13 A. Okay. Whatever the dates on the --  
14 on my --

15 Q. The earlier resume I think has the  
16 precise dates. Right.

17 A. Omni was '96 to '98. So it would be  
18 a couple of years.

19 Q. I think we did this earlier.

20 Let's look at Exhibit 4. You have  
21 May of 1996 through January of '98.

22 A. Yes. That would be the correct --  
23 that would be the correct dates.

24 Q. Okay. And so how many times would

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1 A. No. They pay a lower copay for  
2 generics.

3 Q. All right. They pay a lower copay  
4 for generics and then if it was a branded product,  
5 all branded products were on the -- in essence the  
6 second tier?

7 A. All of the branded products on  
8 formulary were on -- were on the second tier  
9 unless it was a unique product in class.

10 Q. All right. Here's what I'm trying  
11 to understand. There are -- there are some two-  
12 tier formularies when there is a generic and then  
13 there is -- everything else is basically  
14 considered covered except for certain exclusions,  
15 whether it's -- it's certain very high-cost  
16 products. There are other formularies that are  
17 two tier where you have a generic and then you  
18 have branded on formulary and then you have other  
19 things that are not reimbursed at all.

20 Do you know what was the structure  
21 of the two-tier formulary at Omni during the time  
22 period that you were there?

23 A. As I recall, if it wasn't on the  
24 second tier, it wasn't reimbursed.

1 the P&T committee have met during that time period  
2 if they met every six months between May of '96  
3 and June '98? Three or four?

4 A. As I recall, we had three or four  
5 meetings.

6 Q. All right. And do you know whether  
7 or not the estrogen class of products was reviewed  
8 by Omni?

9 A. I don't recall that it was.

10 Q. Did Omni keep minutes of its P&T  
11 committee?

12 A. I don't know. I believe we did.

13 Q. Were you the keeper of the minutes?

14 A. No.

15 Q. Do you know who was?

16 A. It would have been Steve Ondel, who  
17 was the chief of pharmacy benefit. He was a  
18 pharmacist.

19 Q. How many members were on the Omni  
20 P&T committee, if you remember?

21 A. It was a fairly broad group of  
22 physicians who were from various specialties and  
23 various locations within the Omni market. That  
24 would -- as I recall, it was around 15 physicians

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1 and it consisted mostly of doctors from both  
2 Sacramento and Stockton.  
3 Q. What was the staff's role at -- at  
4 Omni as it related to say what drugs go on  
5 formulary?  
6 A. There -- there's a difference here  
7 between the formulary, the P&T committee at Omni  
8 and the P&T committee that's operational at a PBM  
9 level. Did you want to go into that?  
10 Q. This is because you were -- you were  
11 basically using the Integrated -- you were working  
12 through Integrated and on to PCN?  
13 A. Yes. There was -- this was an  
14 opportunity to primarily get buy-in from the  
15 prescribing physicians, that if, for instance,  
16 there wasn't a drug on the formulary that there  
17 was a strong feeling we should have it on the  
18 formulary, that there was a voice -- there was an  
19 opportunity for them to express themselves in that  
20 fashion. And if -- if that -- as I recall, it  
21 didn't arise, but had it arisen -- arisen, one of  
22 the factors that the staff would bring back to the  
23 committee was the financial implications of  
24 breaking a contract.

1 Q. And in the time that you were there,  
2 there was never an occasion where the staff was  
3 asked to make a -- some sort of a financial  
4 analysis of the implications of breaking a  
5 contract; right?  
6 A. Not that I know of, but had that  
7 arisen, they would have been the one asked to do  
8 it.  
9 Q. And at your time with the P&T  
10 committee at PCN for some meetings that you guys  
11 have had so far, have you ever had any  
12 communications with any of the staff members at  
13 PCN about the implications of breaking a contract  
14 with a -- with a pharmaceutical company?  
15 A. No.  
16 Q. Let's go back to your report, which  
17 is Exhibit 1, and if you turn to Page 12, you  
18 state that the primary participants in the  
19 distribution of pharmaceutical products are  
20 pharmaceutical manufacturers, wholesale  
21 distributors, retail pharmacies, mail order  
22 pharmacies, government agencies, physicians, and  
23 PBMs. Do you see that?  
24 A. I do.

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1 Q. Okay.  
2 A. Now, incidentally, in your own Wyeth  
3 documents, the company recognizes that this is a  
4 not uncommon trend to have independent P&T  
5 committees that have great say over what is or  
6 isn't on the formulary and part of their strategy  
7 in dealing with this was to --  
8 Q. I just want to -- we'll get to --  
9 we'll get to -- if you could just answer my  
10 questions, we'll actually get finished and I won't  
11 have to bring you back or go out to Sacramento.  
12 \* \* \*  
13 (Whereupon, a discussion was held  
14 off the record.)  
15 \* \* \*  
16 THE VIDEOGRAPHER: Proceed.  
17 BY MR. DOBIE:  
18 Q. Is what you're saying is that if  
19 there -- if there was a specific demand as applied  
20 to formulary, the P&T committee at Omni existed in  
21 order to basically have another voice to in  
22 essence tweak, to use your words, the formulary  
23 and make some additional product placements?  
24 A. Yes, I think that's fair to say.

1 Q. Okay. How are PBMs distributors of  
2 pharmaceutical products?  
3 A. If they own mail order --  
4 MR. COHEN: Object -- object to the  
5 form.  
6 A. If they own their mail order firm,  
7 they are part of the distribution chain.  
8 BY MR. DOBIE:  
9 Q. And what about in terms of  
10 understanding the chain of distribution; what  
11 are -- the customers, aren't they the end point of  
12 that, the distribution chain?  
13 A. You're looking at the -- at the  
14 slide? Is that what you're looking at?  
15 Q. The slide, your discussion here  
16 about the participants in the distribution system.  
17 I didn't see any mention of the customers.  
18 A. Well, that's -- that's part of the  
19 fundamental problem within the health care market,  
20 is because so many rises, who is the customer? Is  
21 it the patient? Is it the health plan? Who's the  
22 customer here?  
23 Q. So you didn't include the customer  
24 either. You didn't include the patient at least

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1 as somebody in the distribution system. You  
 2 don't -- you don't believe that they are, and  
 3 that's a criticism of --  
 4 A. They --  
 5 Q. -- the --  
 6 A. They --  
 7 Q. -- system. Would you let me finish?  
 8 Is that correct, sir?  
 9 A. The customer is relevant in the  
 10 distribution system on cash payments, a  
 11 cash-paying customer.  
 12 Q. So why didn't you include them in  
 13 the distribution system?  
 14 A. Because they're the end user.  
 15 They're not part of distribution. They receive  
 16 the product at the end point.  
 17 Q. We were talking before about the  
 18 chart that's on Page 13 that you got from Mr.  
 19 Schondelmeyer, and I was asking about how  
 20 comfortable you are with the data that's in there.  
 21 In fact, where it says at the top "Private  
 22 Insurance" and then there's a -- there's a little  
 23 circle there, do you see that?  
 24 A. Uh-huh.

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1 Q. It appears to show private insurance  
 2 contracting with pharmacy benefit managers. Do  
 3 you see that?  
 4 A. I do.  
 5 Q. And, in fact, isn't -- the truth of  
 6 the matter is in most instances it's various  
 7 employer plans, various -- as you mentioned,  
 8 Taft-Hartley union groups and others that are the  
 9 ones that are contracting with PBMs. It's not  
 10 really insurance, is it?  
 11 MR. COHEN: Object to the form.  
 12 A. It's part of a basket. For  
 13 instance, many times the insurance companies are  
 14 administering these ERISA trusts and Taft-  
 15 Hartleys. So a patient here in Philadelphia might  
 16 be carrying in their pocket a card from  
 17 Independence Blue Cross, but, in fact, they're  
 18 just administering the benefit for the teamsters.  
 19 And so the -- as the administrator, they  
 20 frequently would be responsible for generating the  
 21 contract with the pharmacy benefit manager,  
 22 particularly if it's an internal captive.  
 23 BY MR. DOBIE:  
 24 Q. So it's -- there's a lot of

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1 administrators that are out there that, in fact,  
 2 deal with the pharmacy benefit manager and they  
 3 might have helped administer the medical side of  
 4 the equation along with the -- with the pharmacy  
 5 benefit; correct?  
 6 A. There are two broad classes in this  
 7 circle. One is a fully insured product like Blue  
 8 Cross that is serving an ASO contract, which is  
 9 administrative services only. And there is a  
 10 second group, which would be the third-party  
 11 administrators, or TPAs, and it's not infrequent  
 12 in that environment that the consultant like  
 13 Mercer would have a good deal to say about which  
 14 PBM administers the benefit -- the pharmacy  
 15 benefit for the underwriter.  
 16 Q. In the -- using your example before,  
 17 the teamsters union, that's a Taft-Hartley-type  
 18 situation. You used --  
 19 A. Right.  
 20 Q. -- another phrase. That would --  
 21 they would be a TPA in your definition?  
 22 A. No. They're not a TPA.  
 23 Q. What are they --  
 24 A. They are the underwriter. They

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1 would fit in that circle, the private insurers,  
 2 but they would be administered by a TPA that's  
 3 serving as a contractor to the plan and they would  
 4 contract with a PBM.  
 5 Q. All right. But if we're talking  
 6 about the sources of payment for prescription  
 7 drugs, at the end of the day, in the example that  
 8 you used, the teamsters -- have you got a  
 9 teamsters union -- they're the ultimate payer?  
 10 A. That's correct.  
 11 Q. All right. And do you know what  
 12 percentage of the marketplace is, as it relates to  
 13 pharmaceutical products, situations where it is --  
 14 the payer is a plan in essence versus what  
 15 percentage of the marketplace is the payer, an  
 16 insurance company that's basically taking a  
 17 premium in exchange for -- for assuming the risk  
 18 of the pharmacy benefit?  
 19 A. What you're -- I'm not quite sure of  
 20 the answer. I will give you as close as I can  
 21 give you to the answer to respond.  
 22 The size of the fully insured  
 23 market, which would include the indemnity and the  
 24 HMO products, compared with the self-funded

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1 market, which would be the ERISA and Taft-Hartley,  
2 my bet is it's about two-thirds-one-third. I  
3 could easily get you that number. But I don't --  
4 Q. Two-thirds-one-third which way?  
5 A. Two-thirds fully insured, one-  
6 third -- and it varies by market. There are some  
7 markets -- take Hawaii, for instance, where  
8 there's hardly any ERISA trusts. There are other  
9 markets where there is -- a high percentage of the  
10 market is ERISA trusts. So it's a market-by-  
11 market issue.  
12 Q. So it's your belief that in -- as it  
13 relates to -- let me -- let me see if I can refine  
14 this.  
15 It's your belief first that two-  
16 thirds of the market is represented by fully  
17 insured or indemnity-type situations and only one-  
18 third is self-funded?  
19 A. Are within this private insurance  
20 market circuit, yes.  
21 Q. Okay.  
22 A. And that again is just off the top  
23 of my head without having a reference that I could  
24 easily get for you.

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1 Q. All right. Do you know whether or  
2 not that number changes as you go from general  
3 health care, in other words, for physicians and  
4 things like that, as opposed to pharmacy benefit?  
5 In other words, isn't there a greater proportion  
6 of folks that may go for full insurance as it  
7 relates to a health benefit, but when you come to  
8 a pharmacy benefit, that's carved out and they  
9 will self-fund that?  
10 A. Carving out has been in the market  
11 for a number of years. It hasn't been a major  
12 trend. It exists. The general reason why self-  
13 funded and -- and Taft-Hartley trusts exist in any  
14 given market depends more on what is going on  
15 within the state. For instance, if you have an  
16 activist government that does a lot of mandated  
17 covered benefits, let's say reproductive services,  
18 within a given market, the incidence of self-  
19 funded, which is federal law, goes up.  
20 Q. Let me ask you this, because this  
21 is -- the reason I was asking you this, if you go  
22 on to your report on Page 15, you state that "By  
23 1999, only 8 percent of persons with employer-  
24 sponsored health insurance coverage had

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1 traditional indemnity insurance."  
2 What did you mean by that?  
3 A. That's the old kind of insurance  
4 where you could go see any doctor you wanted,  
5 there were no fee schedules, you paid for service  
6 at the time of service, and you would submit a  
7 claim to the insurance company, and after you  
8 reached a certain deductible, you would start to  
9 get a percentage of whatever you paid back.  
10 Q. Where did the other 90 -- where is  
11 this -- where does the other 92 percent fall?  
12 A. Most -- most of it is explained on  
13 that chart here on Page 13. The 90 percent would  
14 be within the circle we were discussing on private  
15 insurance. They would have gone to managed care  
16 products, particularly HMOs, and then the balance  
17 would be in public insurance programs like  
18 Medicare and Medi-Cal and in -- in government  
19 programs of one sort or another like Healthy  
20 Family programs and then the final would be the  
21 uninsured, which would be the self-pay.  
22 Q. Okay. In looking in -- at the  
23 pharmaceutical market, how it works, which is the  
24 discussion the first part of your report -- turn

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1 to Page 40 of your report.  
2 A. I'm sorry. Which page?  
3 Q. Page 40.  
4 A. 40. Okay.  
5 Q. You've got a chart there that says  
6 "Follow the Money."  
7 A. Uh-huh.  
8 Q. "PBM play central role." And again,  
9 is this another document that you -- you  
10 downloaded from the Internet?  
11 A. It's referenced right there where I  
12 got it.  
13 Q. Okay. And did you just -- again  
14 just place it right into your report, make any  
15 changes to it that you recall?  
16 A. Well, we're -- I suppose we're going  
17 to go over this issue of quotations marks. To me,  
18 sourcing the document is the common way to  
19 identify where I got that information.  
20 Q. Okay. And you -- you believe it's  
21 accurate and authoritative?  
22 A. I do.  
23 Q. And in this example here, you've got  
24 the pharmaceutical companies paying rebates to

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1 PBMs. See that?

2 A. I do.

3 Q. And then the percentage of the

4 manufacturers' rebates going to the HMO or

5 employer plan on the one instance and then in the

6 other instance, if it's a health plan enrollees,

7 we've got price discounts for enrollees. Is that

8 your understanding of how that --

9 A. I missed that last part of your

10 question. I'm sorry.

11 Q. I'm -- look -- look at the -- well,

12 let's break it down.

13 Is it your understanding consistent

14 with the document that's in your report that a

15 percentage of manufacturers' rebates are in turn

16 paid to HMO employer plans?

17 A. It is.

18 Q. All right. And is it also your

19 experience that PBMs contract with pharmacies for

20 negotiated price discounts for their enrollees?

21 A. Correct.

22 Q. On Page 13 of your report -- let's

23 go back to that -- you say that there's

24 essentially two categories of pharmacy patients,

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1 cash and third parties.

2 Do you know what percentage of

3 patients are cash and what percentage are third

4 party?

5 A. Well, it's indicated here that as of

6 1999 about 11.6 percent of the market was self-pay

7 for a total of 16.7 billion.

8 Q. And how much is third party?

9 A. It would be the added or summated

10 value of private insurance, public insurance, and

11 government delivery.

12 Q. On Page 13 of your report, again

13 talking about rebates, you say -- in the paragraph

14 that is right before the heading "Establishment,"

15 you say, "In some cases, the drug manufacturer

16 pays a rebate back to the PBM or MCO for specific

17 drugs dispensed to their members that are on the

18 PBM or MCOs' formularies"; right?

19 A. Correct.

20 Q. And then on Page 14, you talk

21 about -- in the one, two, three, four, fifth

22 paragraph down, you say that "PBMs also" -- "PBMs

23 also enter into contracts to obtain rebates from

24 manufacturers in exchange for placement on the

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1 PBM's formulary"; right?

2 A. Correct.

3 Q. All right. And again, this is an

4 area that you have no personal experience in?

5 A. Let me rephrase that. I have no

6 personal experience negotiating these contracts.

7 I never said that I had no experience with these

8 contracts or their effect in the market.

9 Q. Well, the -- we've talked about the

10 effect of the market and we can -- we'll cover

11 that a little bit more. But the fact of the

12 matter is is through your experience have you

13 learned that this is actually a fairly common

14 practice, for drug manufacturers to pay rebates to

15 managed care organizations?

16 A. Yes, it is common to pay. The

17 percentage is the issue. The fact that they pay

18 part of the rebate initially -- okay. I won't.

19 Q. Is the answer yes?

20 A. The answer is they do pay rebates.

21 Q. And is it -- is it -- is it your

22 experience that PBMs enter into contracts to

23 obtain rebates from the manufacturers in exchange

24 for being placed on the formulary?

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1 A. Placement on the formulary?

2 Q. Yes.

3 A. Yes.

4 Q. All right.

5 Q. And --

6 A. And Wyeth's documents support that.

7 Q. All right. What Wyeth documents are

8 you talking about?

9 A. We can go through your contracts if

10 you'd like, but a placement on second versus third

11 tier had different rebate amounts paid to the

12 PBMs.

13 Q. So it's your belief that Wyeth's

14 contracts pay rebates depending upon whether or

15 not they put Premarin on the second or the third

16 tier?

17 A. That and about 18 other variables,

18 yes.

19 Q. All right. And do you know whether

20 or not there's any rebates that are payable at all

21 for simply putting Premarin on their formulary in

22 any contract?

23 A. To put --

24 Q. Let me repeat the question.

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1 A. You're going to have to --  
2 Q. In this case, sir, are you -- are  
3 you aware of whether or not Wyeth paid rebates to  
4 any PBM or any HMO for putting Premarin on  
5 formulary?  
6 A. Yes. Yes. We have multiple  
7 examples of where Wyeth paid rebates for being  
8 placed on the formulary.  
9 Q. All right. And let me make sure  
10 I'm -- we're being clear on this.  
11 One way to pay -- do you know what  
12 access rebates are?  
13 A. I'm not -- explain the term and  
14 I'll --  
15 Q. Are you familiar with the -- with  
16 the practice of pharmaceutical companies to pay  
17 access rebates or moneys to PBMs or managed care  
18 organizations in exchange for being placed on  
19 formulary?  
20 A. I'm familiar with rebates being paid  
21 for being on a formulary, on a given position in  
22 the formulary.  
23 Q. Are you -- are you familiar with the  
24 practice -- of the differences between paying

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1 money for being placed on formulary as opposed to  
2 manufacturers paying money for particular plans  
3 achieving certain market -- certain market  
4 share --  
5 A. Sure.  
6 Q. -- objectives?  
7 A. Yes.  
8 Q. All right. How does -- how does  
9 that work in the marketplace, if you know?  
10 A. Again, that's -- that's -- that's  
11 documented through the footnotes on Wyeth's own  
12 contracts.  
13 You're referring to two kinds of  
14 rebate contracts. One is for inclusion on the  
15 market -- on the rebate -- on the -- on the  
16 formulary and the second is what would be a  
17 performance-based contract that reimbursed based  
18 on market share movement favorably towards  
19 Premarin and in other instances on a performance  
20 base the diminution of Cenestin's market position.  
21 Q. Do you -- do you know in this case,  
22 sir, whether or not the -- or whether in the  
23 industry, whether market share performance rebates  
24 are common?

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1 A. Market -- yes, my -- my  
2 understanding is that it's common and is more  
3 common now than it used to be that rebates are  
4 tied to performance.  
5 Q. Right. Do you know whether simply  
6 obtaining -- how do you know that?  
7 A. Again, it's the discussion you and I  
8 have had up till this point where I have had the  
9 opportunity to talk with individuals in the  
10 industry about it.  
11 Q. Okay. And who are -- who are the  
12 individuals, sir?  
13 A. Same cast of players that I gave to  
14 you --  
15 Q. Mr. Scull.  
16 A. -- for the -- yes.  
17 Q. The pharmacist. Mr. Bystrom.  
18 A. And Mr. Bystrom would be the chief  
19 of -- that I would have as my sources.  
20 Q. All right. And then the practice of  
21 paying rebates for simply being on formulary as  
22 opposed to hitting certain market share targets,  
23 is that practice common in the industry?  
24 A. I think both are common in the

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1 industry. I think, though, that it is a moving  
2 picture, not static, that the -- that the issue of  
3 performance-based rebate contracts are much more  
4 common today than they were five years ago.  
5 Q. Do you know how many manufacturers  
6 today use performance-based rebates as opposed to  
7 simply rebates for putting you on formulary?  
8 A. My -- my -- my understanding is  
9 almost all of them use performance-based rebates.  
10 Q. Okay. How about five years ago,  
11 1999?  
12 A. Five years ago, it wasn't as common.  
13 It was more common to be placed, because on a  
14 second-tier arrangement it was -- you know, if  
15 you're on the formulary, you're -- you -- that's  
16 what you wanted. If you're in a three- or four-  
17 tier structure, the client has -- or the patient  
18 has access to the third tier. Then it becomes an  
19 issue of how you structure the plan as far as the  
20 amounts of the co-pays for the different tiers and  
21 whether you put in place negative factors like  
22 prior authorization, which Wyeth demanded on a  
23 number of its -- wrote into a number of its  
24 contracts, which would be a reason to increase the

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1 rebate, because it moves market share.  
2 Q. Do you know whether Duramed sought  
3 performance rebates from any PBMs?  
4 A. I do not.  
5 Q. Do you know whether Duramed sought  
6 access rebates from any PBMs?  
7 A. Again, I do not know.  
8 Q. In assessing what impact Wyeth's  
9 rebate contracts may have had in the marketplace,  
10 does it matter to you at all what type of  
11 agreements or whether or not Duramed was seeking  
12 to have rebate contracts itself?  
13 A. My opinion -- good question. The  
14 answer is that we're talking apples and oranges.  
15 Wyeth is apples. Duramed is oranges. It's one  
16 thing to be in a dominant position with a MCO or a  
17 PBM relying on the revenue from your existing  
18 contracts and a new player. And so I don't think  
19 understanding Cenestin's strategy or rebate  
20 structure made much difference, and I illustrated  
21 that in a -- in a graph.  
22 Q. Would it -- would it matter to you  
23 at all in terms of if Duramed did not actually  
24 seek a formulary position in any managed care

1 bring a new product on the market and completely  
2 ignore the rebate issues.  
3 Q. All right. Would it surprise you if  
4 you learned that Duramed decided not to seek  
5 formulary position at certain managed care  
6 organizations?  
7 A. Well, it depends on the managed care  
8 organizations. I mean, it's one thing not to go  
9 for it on a dominant player like HealthNet in  
10 California, and it's quite another to go for a  
11 marginal player in California like, say, CIGNA.  
12 Q. Right. So would it be -- would it  
13 surprise you or would it be important for your  
14 opinions to learn whether or not Duramed did, in  
15 fact, seek or not seek formulary placement with  
16 major managed care providers, PPMs and HMOs?  
17 A. I think that would be helpful to  
18 know.  
19 Q. All right. And -- but to date, you  
20 have not undertaken that inquiry?  
21 A. No, I really haven't.  
22 Q. Oh. I asked you a question in your  
23 last deposition about whether or not it was common  
24 to have rebate agreements with Medicaid or Medi-

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1 organizations? Would it matter to your opinion?  
2 A. Yes, it would matter to my opinion.  
3 Q. How so?  
4 A. Again, you're -- you're good at  
5 creating hypotheticals that are hard for me to  
6 grasp.  
7 Q. Let me -- let me -- let me say it  
8 broader.  
9 Does it -- would it matter to  
10 your -- I mean, you told us you're not aware of  
11 what type of rebate contracts Duramed did or  
12 didn't offer to -- to managed care organizations;  
13 right?  
14 A. What I'm saying --  
15 Q. Yes or no.  
16 A. All right. Yes, it would make a  
17 difference.  
18 Q. Okay. And so it would make a  
19 difference if Duramed, in fact, did not go out and  
20 offer PBMs a managed care agreement, their own  
21 managed care agreement, in terms of why they were  
22 or weren't on formulary?  
23 A. Yes. It would surprise me if a --  
24 if a sophisticated marketer like Duramed would

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1 Cal plans. Do you recall that?  
2 A. I don't recall that, but I'm not  
3 surprised that we discussed it.  
4 Q. All right. Because, in fact, PCN  
5 has a lot of Medicaid and Medi-Cal type plans that  
6 it administered historically; correct?  
7 A. Correct.  
8 Q. And you're familiar with that?  
9 A. Correct.  
10 Q. Are you familiar with the fact that  
11 PCN, in fact, does -- that there are rebates that  
12 are earned in connection with products that are on  
13 formulary, Medicaid and Medi-Cal formulary?  
14 A. I'd be surprised if they didn't have  
15 rebates on brand products.  
16 Q. And when did you learn that, sir?  
17 A. When did I learn they had rebates?  
18 Q. Yes.  
19 A. I didn't learn that. You -- you  
20 asked me whether I'd be surprised, and I was  
21 saying that I wouldn't be surprised, that you  
22 would not leave money on the table.  
23 Q. So is it -- is it your  
24 understanding -- did you know -- do you know

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1 sitting here today whether the plans -- Medicaid  
2 or Medi-Cal type plans receive rebate dollars?  
3 A. My assumption is they do, but I  
4 don't know it and I haven't seen the contract.  
5 Q. Do you know whether or not a hundred  
6 percent of the rebate dollars are as a general  
7 matter passed on to Medicaid and Medi-Cal plans by  
8 PCN?  
9 A. They -- it is passed on -- not a  
10 hundred percent, but it's passed on by PCN. PCN  
11 is noted in the industry as one of the most  
12 transparent PBMs and passes through some of the  
13 highest percentages within the industry of  
14 rebates. But it's not a hundred percent. Usually  
15 it's 80-20, I believe.  
16 Q. Have you ever seen your form  
17 contract?  
18 A. No.  
19 Q. Have you ever had a discussion with  
20 your pharmaceutical contracts administrator about  
21 that?  
22 A. Yes.  
23 Q. And did they -- did they tell you  
24 that they had a template?

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1 A. They -- they told me that in -- that  
2 the number I just gave you on a 80-20 split is  
3 what they usually put into the contract, but I  
4 have not seen the contract.  
5 Q. When did you have the discussion?  
6 A. Again, this is over the course of  
7 the past year and it would have been with the  
8 players that I've identified, plus Sue Navis was  
9 the network provider for the pharmacies, and the  
10 chief of the professional services division at  
11 PCN, which -- which was Amy Chin, as I recall,  
12 told me about that.  
13 Q. Okay. So in the 80-20 -- here's all  
14 I'm trying to understand. Do you have any  
15 understanding as to the difference between what  
16 the PCN contract template, what your typical  
17 contract is when it's a Medicaid-Medi-Cal plan on  
18 the one hand versus on the other hand a private  
19 plan?  
20 A. In general, it's consistent across  
21 the board, is my understanding, that PCN passes  
22 through the majority of the rebate to the client.  
23 Q. And -- and you said 80 percent of it  
24 in the instance of -- of a private plan. Do you

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1 know what it is if -- if it's a Medicaid or a  
2 Medi-Cal plan?  
3 A. It's for both.  
4 Q. All right. That -- that was my  
5 question.  
6 A. However, the percent of rebates in  
7 the Medi-Cal are lower because there's a much  
8 higher percentage of generic on the formulary.  
9 \* \* \*  
10 (Whereupon, Gibson Exhibit 13 was  
11 marked for identification.)  
12 \* \* \*  
13 BY MR. DOBIE:  
14 Q. Let me show you what we marked as  
15 Exhibit 13.  
16 For the record, Exhibit 13 is a  
17 document produced by PCN's contract manager in  
18 response to a subpoena that we served as part of  
19 the preparation for this deposition, and as you --  
20 as you can see here, she says that in  
21 Pharmaceutical Care Network their boilerplate  
22 contract is 80-20 rebate split on the commercial  
23 business. And then she's got another boilerplate  
24 on the managed Medicaid accounts as well.

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1 Sir, if I turn your attention to the  
2 very -- the last page of the document.  
3 A. Are there two documents here or one?  
4 Q. It's -- I think I can walk you  
5 through it. Go to the very last page of  
6 Exhibit -- Exhibit 13. Exhibit 13 is just a  
7 single page that differs from the prior contract  
8 and -- go to Paragraph 6.7.  
9 A. On -- on the last page --  
10 Q. Yes, sir.  
11 A. -- of the exhibit?  
12 Q. And you'll notice that --  
13 A. 6.7, it starts, "PCN will collect"?  
14 Q. Uh-huh.  
15 A. Okay.  
16 Q. And then the second sentence says,  
17 "PCN will remit to payer 90 percent of the  
18 reimbursement savings collected by PCN." Do you  
19 see that? "The balance" --  
20 A. I do, yes.  
21 Q. -- of the reimbursement savings  
22 collected, 10 percent, will be retained by PCN in  
23 consideration of the performance of its  
24 obligation"; right?

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1 A. Correct.

2 Q. And then if you go to 6 point --

3 A. Now, is this -- is this part of this

4 document or is this part of another document and

5 this is the only page from it?

6 Q. This is -- this is the only page --

7 I think that your Medicaid boilerplate contract is

8 what --

9 A. Okay. And the other one is the

10 commercial?

11 Q. Yes, sir.

12 A. Okay.

13 Q. But -- I guess the question that I

14 have for you, you've never seen either one of

15 these documents before?

16 A. If I have, I don't recall it.

17 Q. And turning to Paragraph 6.7 of the

18 first contract.

19 A. That would be on Page 9 again?

20 Q. No. 5 of the -- of the document.

21 A. Okay. Yes.

22 Q. It notes that PCN will remit to

23 payers 80 percent of the reimbursement savings

24 collected by PCN and the balance of the

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1 reimbursement savings collected, 20 percent, will

2 be retained by PCN in consideration of the

3 performance of its obligations.

4 A. Right.

5 Q. Right. And sir -- so generally

6 speaking, at least at PCN, I assume that we can

7 agree that the rebate dollars that are collected

8 by PCN are passed on in the vast majority of

9 instances to the plans, whether it's a Taft-

10 Hartley or an ERISA plan or something else?

11 A. At PCN, yes.

12 Q. And -- and by -- by these rebates

13 being passed on to those plans, if it's a -- let's

14 say it's the teamster union, it lowers the

15 teamster union's cost for the pharmacy benefit

16 that it provides to the members; correct?

17 A. Not necessarily.

18 Q. Doesn't -- doesn't PCN's passing on

19 of the rebate to the -- to the union or whoever

20 it's administering the benefit for lower their

21 cost over what it would otherwise be for the

22 pharmaceutical product?

23 A. Again, not necessarily.

24 Q. Okay. And why not?

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1 A. If you incentivize, through a rebate

2 structure, the use of a -- of a brand product when

3 a generic is appropriate, you're increasing the

4 cost to the client.

5 Q. Well, in -- at PCN, is that what

6 you're doing? Are you incentivizing people to use

7 generics or are you incentivizing them to use

8 branded?

9 A. And are we talking -- at PCN, in

10 both the commercial and the Medi-Cal, we would be

11 encouraging the generics.

12 Q. Okay. So --

13 A. Which is not the norm in the

14 industry.

15 Q. But I'm talking about PCN.

16 A. Got you.

17 Q. So at PCN --

18 A. Which is -- which also is just a

19 minor player in the industry.

20 Q. At PCN, generally speaking, it would

21 generally be the case that passing on of the

22 rebate dollars, 80 percent of them or 90 percent

23 of them would lower the cost to the particular

24 employer plan or union plan that's paying for the

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1 health care; right?

2 A. You've -- you've -- you've built

3 walls around this, and the answer to that is yes.

4 Q. I'm not trying to build walls around

5 it. I'm talking about PCN.

6 A. Yes.

7 Q. Which is -- because that's where you

8 work; right?

9 A. That's right. It's a small plan and

10 it's unique in the way it administers the benefit.

11 Q. All right. But it's where you work

12 and it's where you have your experience; right?

13 A. Well, I've got experience beyond

14 that.

15 Q. I understand that.

16 A. But yes.

17 Q. All right. But it's a significant

18 part of your experience and that at least at PCN

19 these rebate dollars that are paid would lower the

20 cost to the particular plans; right?

21 A. Yes.

22 Q. Okay. Now --

23 MR. COHEN: Gordon, excuse me. I

24 have a request. I know these -- this PCN

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document is from the subpoena that you issued against PCN. I made a request to counsel for PCN to get served with whatever they served you with, and I never got a copy. So I would just make a request that any documents that you -- you received, that I get a copy of that.

MR. DOBIE: I actually thought he was going to bring them today. That's what she told me.

MR. COHEN: We never received that.

MR. DOBIE: The last I talked to her was Friday afternoon, Jay, after you and I spoke and -- well, over the weekend I was on a Boy Scout trip with my kids and then getting ready for a deal yesterday in Florida on Sunday and Monday. And so we got this in at some point over the weekend. And that's it. That's the only document.

MR. COHEN: This is the only document? And --

MR. DOBIE: I've asked her for others and she promised that she would provide others.

managed Medicaid agreements so that you can see the difference."

MR. COHEN: So I have what you have.

MR. DOBIE: You've got it.

MR. COHEN: Okay.

MR. DOBIE: But I'd like to get some more. I was hoping -- but that's all we've received.

BY MR. DOBIE:

Q. Okay. And then -- sir, let me ask you this: Have you read the depositions of any of the executives from Medco that were deposed in this case?

A. I may have. I would have referenced it in my footnotes if I had used it.

Q. Okay. It's --

A. And you've got a list of the documents --

Q. Yes.

A. -- that I --

Q. It's not either on your list of documents and it's not in your -- any of the footnotes. So is it safe to say that you haven't read either of the depositions of the Medco

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MR. COHEN: We haven't heard from her.

Can I ask you -- this seems to be -- the page numbers are out of order. Did you extract any pages from this or did they do the extraction?

MR. DOBIE: She -- she sent us an e-mail that had those documents and that cover letter and nothing else.

MR. COHEN: So when it goes from Page --

MS. WARD: And I'll represent that there were two attachments to the e-mail and it's referenced in her e-mail that says -- she says it's boilerplate with a Word document, which is the first document I attached to the e-mail, and that's a sample contract. And the second page -- or the final page of the exhibit --

MR. COHEN: The Page 9?

MS. WARD: Right. Was a PDF of one page, and she represented in the e-mail that "I've included it" -- well, there's a typo, but "a copy of the page from one of our

executives?

A. I think so. I'll qualify it that I could be wrong, but I don't think so.

Q. Well, they weren't deposed in the Duramed case, so -- Mr. Cohen pointed out before there may be things that you saw in Duramed, but they weren't deposed in that case.

So the only documents that you would have reviewed were the documents from the Duramed case, the materials that are cited previously in your --

A. Correct.

Q. -- in the exhibit as well as in your report; right?

A. Right.

Q. And would you have wanted to know that at Medco, in fact, Premarin rebates were passed on to health plans at between 83 and 90 percent of the time between 1999 and 2002?

A. That's interesting news. However, the rebates can take many forms. In other words, you can have, as we discussed, positioning and -- and performance rebates. There's also administrative rebates. I don't know if that's

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1 included in that number or not. And there's a  
2 whole separate rebate structure for mail order.  
3 Q. Well, let me -- let me show you a  
4 document here that's been marked as Odansik 1, and  
5 it discusses the two types of rebate dollars that  
6 Medco received from Wyeth, and Mr. Odansik and the  
7 other executive from Medco, Mr. Narden, testified  
8 concerning Medco and the pass-on of rebates and  
9 testified under oath, like at PCN, that they pass  
10 on rebates at between 80 and 90 percent of the  
11 time on Premarin. Not on every product, but on  
12 Premarin.

13 A. So the first line here -- not -- the  
14 first line is the date, but the first line is the  
15 base formulary rebate pass back is 91, 83, 88, 90,  
16 and 88?

17 Q. Yes, sir.

18 A. And what's the second line?

19 Q. Those are incentive rebates and  
20 those are generally, as you indicate -- as  
21 indicated here, is only 2 percent passed on.

22 A. Now, are these -- is this a summated  
23 number, so that 91 plus 2 percent?

24 Q. No. The incentive rebates, those

1 performance through all sorts of activity,  
2 whipping up action of physicians and sending out  
3 their own folks, if they were able to achieve  
4 that, that was a rebate dollar that Mr. -- Narden  
5 and Mr. Odansik said they, pursuant to their  
6 agreements with their health plans, could keep  
7 that.

8 A. Okay.

9 Q. But -- but -- let me just finish.

10 But the top number is the number  
11 that was actually where rebates were -- generally  
12 came in. In other words, if -- if you were within  
13 zero to 2 percent of national market share or zero  
14 and 3 percent -- and I'm using the numbers  
15 loosely, but -- but essentially the vast majority  
16 of Medco plans would have never hit the higher  
17 threshold, the incentive rebate passback.

18 A. Okay.

19 Q. So he testified that, in fact, 90  
20 percent of the rebates on Premarin were passed on.  
21 All right?

22 A. Well --

23 MR. COHEN: I'm just going to  
24 interject an objection to the form to the

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1 are -- the witness testified that to the extent  
2 that a plan achieved performance over -- above the  
3 national market share of some very high  
4 percentage, a percentage that rarely, if ever, was  
5 hit by Medco, hence the Cenestin amendment and so  
6 on, those rebates would only be passed on in --  
7 at -- by contract at 2 percent of the time.

8 A. So that's 2 percent of the total  
9 rebate that they got --

10 Q. Yes?

11 A. -- or what does that mean?

12 Q. That would be that by contract they  
13 would only have to pass on --

14 A. 2 percent --

15 Q. -- 2 percent.

16 A. -- of the performance rebate.

17 Q. If they ever hit the high -- no, not  
18 of the performance rebate. If they hit certain  
19 tiers.

20 So if it's a contract that provides  
21 that we will pay a rebate to the extent that the  
22 plan is 5 percentage points over national -- let's  
23 just use that as a -- as the example. All right.  
24 If Medco was successful in achieving that type of

1 extent that the transcript is being  
2 characterized, that the transcript speaks  
3 for itself.

4 MR. DOBIE: That's fair.

5 BY MR. DOBIE:

6 Q. But let's say hypothetically 80 to  
7 90 percent of Premarin rebates were, in fact,  
8 passed on by Medco to the health plans.

9 Is this the first time that you're  
10 hearing that today, sir?

11 A. Yes.

12 Q. Would that have been relevant to  
13 your opinions?

14 A. It would be more relevant if I had  
15 the rest of the chart.

16 Q. Okay. There's nothing else to the  
17 chart.

18 A. Well, there's more rebates than  
19 this. That may be all you've got on the chart.

20 Q. This is all that Medco produced in  
21 this case.

22 A. Well, I'm just saying there's more  
23 rebate structure in your own documents --

24 Q. Why --

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1 A. -- how Wyeth contracted.  
 2 Q. No, I'm not talking about how Wyeth  
 3 contracted. I'm talking about between Medco and  
 4 the health plans. All right.  
 5 Assume -- you can view this as a  
 6 hypothetical. Assuming that the testimony -- the  
 7 undisputed testimony is that somewhere between 80  
 8 and 90 percent of Medco's rebates are passed on to  
 9 health plans, that might impact your conclusions,  
 10 would it not, in terms of the benefit of rebates  
 11 on the Premarin product; right?  
 12 A. I don't think I'm articulating my  
 13 problem here. All right.  
 14 If that -- if this were the totality  
 15 of the rebate structure, this would be helpful.  
 16 It is not. The rebate structure also contains  
 17 administrative fees which are well known in the  
 18 industry, and Medco's one of the most aggressive  
 19 players in that, and they are -- there are rebate  
 20 structures that exist for mail order, and Medco's  
 21 one of the most aggressive players there. So  
 22 you've got -- as this sits here for me,  
 23 substantial portions of the rebate dollars aren't  
 24 accounted for.

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1 Q. Have you made any effort, sir, to  
 2 figure out whether or not -- the amount of Wyeth  
 3 rebate dollars paid to Medco versus the amounts of  
 4 administrative fees?  
 5 A. All I know is the contracts that we  
 6 obtained through discovery and how those broke  
 7 out.  
 8 Q. Okay. You -- you never -- Mr. Cohen  
 9 or no one else ever sent you any information that  
 10 explained how rebates were, in fact, passed on by  
 11 Medco to the health plans and its clients?  
 12 A. Not that I recall.  
 13 Q. If, in fact, Medco did pass on  
 14 between 80 to 90 percent of the rebate dollars  
 15 that it received from Wyeth and --  
 16 A. In total.  
 17 Q. In total. And the administrative  
 18 fees that they received from Wyeth were less than  
 19 1 percent of the rebate dollars that they  
 20 received, wouldn't it be a situation much like  
 21 what you believe the situation to be at PCN?  
 22 A. It would. I don't -- I find it not  
 23 credible, but it would.  
 24 Q. Okay. Let's go to another example.

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1 THE WITNESS: Can we take a quick  
 2 break?  
 3 MR. DOBIE: Sure.  
 4 THE WITNESS: I've been consuming a  
 5 lot of water.  
 6 MR. DOBIE: Okay.  
 7 THE VIDEOGRAPHER: Going off the  
 8 record. The time is 5:01 p.m.  
 9 This is the end of Tape No. 3. The  
 10 time is 5:02 p.m. We're now off the record.  
 11 \* \* \*  
 12 (Whereupon, a short recess was  
 13 taken.)  
 14 \* \* \*  
 15 THE VIDEOGRAPHER: This is the  
 16 beginning of Tape No. 4. The time is 5:12  
 17 p.m. We're back on the record.  
 18 BY MR. DOBIE:  
 19 Q. Dr. Gibson, have you reviewed the  
 20 deposition of Blue Shield of California --  
 21 A. No.  
 22 Q. -- Lee Sagapi?  
 23 Q. Did you review the deposition of  
 24 Express Scripts?

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1 A. No. I did review some of the  
 2 Express Scripts contracts.  
 3 Q. Have you reviewed any of the  
 4 documents that have been produced by any of the  
 5 PBMs in this case that address the issue about how  
 6 much rebate dollars are being passed on to health  
 7 plans?  
 8 A. These would be in the depositions?  
 9 Q. Yes, sir.  
 10 A. The only deposition -- we'll make  
 11 this easy. The only deposition I have read was my  
 12 old deposition. I believe in the Duramed case --  
 13 I don't know if I read Bystrom's deposition or  
 14 not. But those were really the two depositions  
 15 I've read.  
 16 Q. All right. And wouldn't you want to  
 17 review the testimony concerning how much rebates  
 18 are passed on in order to reach the conclusions  
 19 that are in your report if you, in fact, knew that  
 20 there was such evidence?  
 21 A. I wanted to know what the rebate  
 22 structure was between the manufacturer and the  
 23 PBM. That was my primary interest.  
 24 Q. And so you weren't interested to the

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1 extent to which rebates were passed on between the  
 2 PBMs and the health plan sponsors?  
 3 A. I did not look at that.  
 4 Q. Okay. And you weren't interested in  
 5 it?  
 6 A. Not particularly.  
 7 \* \* \*  
 8 (Whereupon, Gibson Exhibit 14 was  
 9 marked for identification.)  
 10 \* \* \*  
 11 BY MR. DOBIE:  
 12 Q. One of the documents that you did  
 13 cite in this case I've marked as Exhibit 14.  
 14 MR. COHEN: Shouldn't this be 15?  
 15 MR. EINHORN: I think the other one  
 16 was marked 14.  
 17 MR. DOBIE: I'm sorry. Oh, we  
 18 didn't mark it? I just use the Medco --  
 19 okay.  
 20 MR. COHEN: Okay. I thought it was  
 21 marked. I'm sorry.  
 22 BY MR. DOBIE:  
 23 Q. For the record, Exhibit 15, sir, can  
 24 you identify for the record?

1 here in the report that, in fact, from 1998 to  
 2 2001 rebates that PBMs paid to the three Federal  
 3 Employee Health Benefit Programs effectively  
 4 reduced plans' annual spending on prescription  
 5 drugs by 3 to 9 percent. Do you see that?  
 6 A. I do.  
 7 Q. All right. Did you reference that  
 8 in your report in any way?  
 9 A. No.  
 10 Q. And why not?  
 11 A. Because it is a complex number to  
 12 arrive at.  
 13 Q. All right. Did you think this --  
 14 this was a reliable source for other purposes?  
 15 A. I did. And I think that's a  
 16 reliable number, but it doesn't give you enough  
 17 information to really answer it -- or to use it.  
 18 Q. Then don't you think as it relates  
 19 to the people who are members of the Federal  
 20 Employees' Health Benefit Program to see that  
 21 rebate dollars paid by PBMs to them reduce their  
 22 annual spending on prescription drugs 3 to 9  
 23 percent?  
 24 A. It --

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1 A. Yes. It is a -- it is a  
 2 presentation set of slides from the GAO dated June  
 3 26 of 2003 and it deals with the subject of  
 4 pharmacy benefit managers.  
 5 Q. So "The Role of Pharmacy Benefit  
 6 Managers in Federal Employees' Health Benefits  
 7 Programs" is what it's entitled?  
 8 A. Right.  
 9 Q. Did you attend this meeting, by any  
 10 chance?  
 11 A. No.  
 12 Q. And where did you get this document?  
 13 A. As I recall, I either found it  
 14 through a reference or I picked it up directly off  
 15 of a search on the Internet.  
 16 Q. Can I draw your attention to Page 9,  
 17 if I could.  
 18 A. Okay.  
 19 Q. All right. And this is a document  
 20 that you cited in your report; correct?  
 21 A. The slide part of it?  
 22 Q. Yes.  
 23 A. Yes, it is.  
 24 Q. And -- and you note -- or it notes

1 Q. Isn't that a -- isn't that a useful  
 2 piece of information?  
 3 A. It's an interesting piece of  
 4 information. It's a useful piece of information.  
 5 It, however, is one dimensional in least a three-  
 6 dimensional world.  
 7 Q. Do you understand whether or not the  
 8 same way that PCN passes on 90 percent or more of  
 9 its rebate dollars to Medi-Cal in California  
 10 plans, whether or not the -- whether the other  
 11 PBMs, the major PBMs in the country, Express  
 12 Scripts, Medco, AdvancePCS, and others, whether  
 13 they, in fact -- they pass on an equally high  
 14 percentage of their rebate dollars?  
 15 A. They do not.  
 16 Q. How do you know that?  
 17 A. That -- that is -- the best source  
 18 that I would give you on that -- and I don't have  
 19 the reference and I didn't put it in my  
 20 document -- was about two or three years ago the  
 21 then president of AdvancePCS gave an address to a  
 22 trade convention, a national trade convention. He  
 23 showed -- and this has never been published -- a  
 24 graph with two Y axes. On the X axis was time by

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1 year and on the first Y axis was revenue generated  
2 by -- by service; i.e., administering the benefit  
3 plan and processing claims and all of that sort of  
4 thing.

5 On the second Y axis was the  
6 percentage of revenue based on rebates.

7 The two graphs intersected with  
8 the -- in the earlier years, back in the early  
9 '90s, the majority of the revenue for the plans --  
10 for the PBMs being generated from servicing the  
11 account to very little of the revenue coming from  
12 servicing the account, with the percentage of  
13 revenue coming to the PBM from rebates going in  
14 the opposite direction.

15 Q. Do you know how they account for  
16 rebate dollars, how a pharmacy benefit manager  
17 accounts for -- do they -- do they take the rebate  
18 dollars in in revenue in the first instance,  
19 record that as revenue, and then account for it  
20 differently as they pass it on to health plans?  
21 Do you know how they do it as an account?

22 A. I would think they probably all have  
23 different accounting rules.

24 Q. The --

1 Q. We'll come back to the Medi-Cal and  
2 Medicare reimbursement.

3 Do you -- but since you raise a  
4 different point, which is -- has to do with --  
5 with Wyeth's contracting as it relates to  
6 administrative fees, do you know whether or not  
7 Wyeth pays administrative fees or any other rebate  
8 dollars to PBMs at any greater or lesser amount  
9 than owner pharmaceutical companies?

10 A. No.

11 Q. Do you know --

12 A. I know that -- I know that the  
13 general range, they were in it, which is somewhere  
14 between 2 and 5 percent.

15 Q. Okay. Do you know, for example, at  
16 Express Scripts what amount of nonrebate revenue  
17 Express Scripts received from Wyeth?

18 A. Nonrebate revenue?

19 Q. Yes, sir.

20 A. Well, if you -- if you -- if you  
21 classify rebate in the broadest sense like I just  
22 did, both revenue for placement on the formulary  
23 and positioning, revenue on rebate for -- for  
24 performance, and all of the other things that I've

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1 A. I can look at their annual statement  
2 and then you could say.

3 Q. Are you assuming, sir, that because  
4 a high percentage of their revenues are rebate  
5 dollars that that means that they don't pass on a  
6 high percentage of the rebates to plans? Is that  
7 an assumption?

8 A. I don't think they're as high as  
9 you -- the question you asked was do I think that  
10 their rebate dollars and percentages are as high  
11 as the percentages that you find with -- with  
12 PCN's.

13 Q. To federal employee health plans.

14 A. Yes, but understand what I'm saying.  
15 It's a complex way in which rebates are accounted  
16 for. And your client is playing heavily in this  
17 market with more and more of the rebate going to  
18 administrative fees and to the mail orders. The  
19 reason for going with higher administrative fees  
20 is it gives them a way of getting around the 15  
21 percent number that is the upper limits -- roughly  
22 the upper limits for rebate contracting with  
23 commercial accounts, because it would affect the  
24 Medicare and Medi-Cal rates.

1 cited in my contract, plus administrative rebates,  
2 plus mail order rebates, if -- if I'm answering  
3 within that context, are you asking me how much  
4 other things they pay?

5 Q. What you're saying is that there's a  
6 class of rebate dollars -- or it's a class of  
7 dollars that's paid to the managed care -- to the  
8 PBM that's not passed on; correct? That's your  
9 point?

10 A. Right.

11 Q. All right. Do you know what  
12 percentage Wyeth paid to Express Scripts that was  
13 not passed on --

14 A. No, I don't.

15 Q. -- to health plans?

16 A. I know that, for instance, what you  
17 just gave us here on Medco, which I find not  
18 credible. But no, I don't.

19 Q. All right. And do you -- do you  
20 know -- would you be interested --

21 A. And actually, there -- there would  
22 not be any reason that anyone would know that.  
23 That's not -- that's not published.

24 Q. Okay. Well, you're an expert in

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1 this case. Did you ask --  
 2 A. Yes, but this -- these are  
 3 proprietary things. Just because you're an expert  
 4 doesn't mean you know proprietary information.  
 5 Q. Let me finish the question.  
 6 Did you ask Mr. Cohen to review the  
 7 Express Scripts documents or the depositions to  
 8 see what portion of their revenues that they  
 9 received from Wyeth were passed on?  
 10 A. No, I did not.  
 11 Q. Did you ask to review what portion  
 12 of the revenues that they received from Wyeth were  
 13 rebate dollars that were passed on as opposed to  
 14 administrative fees or other things that were not?  
 15 A. I confine my interest to what the  
 16 contract was between Wyeth and Express Scripts and  
 17 what those rebate structures were.  
 18 Q. Okay. But you've made assumptions  
 19 in your report that there are certain fees that  
 20 these managed care companies are -- are receiving  
 21 from pharmaceutical companies like Wyeth that are  
 22 not being passed on. So why would you not have  
 23 been interested in seeing whether, in fact, a  
 24 major PBM like Express Scripts was, in fact,

1 structured, and how did they affect the market.  
 2 Q. Okay. And -- and I guess what I  
 3 would ask is, how can you say how they would  
 4 affect the market, which includes patients,  
 5 physicians, health plans, all of these other  
 6 groups that you say are part of the market,  
 7 without understanding how much those Wyeth rebate  
 8 dollars on Premarin were, in fact, passed on?  
 9 MR. COHEN: Objection. Asked and  
 10 answered.  
 11 A. Because you have to understand how  
 12 the MCO or the HMO treats the rebate that comes  
 13 back in. In other words, frequently it's not  
 14 carried on the books as a part of ongoing  
 15 operations. They're treated as one-time infusions  
 16 of cash that are not part of the budget.  
 17 I know at Omni that's how we treated  
 18 the rebates.  
 19 BY MR. DOBIE:  
 20 Q. You treat it as one-time infusions  
 21 of cash?  
 22 A. These -- you couldn't budget and  
 23 count on it, so it was generally carried not as a  
 24 budget revenue but as one-time transactions on an

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1 receiving rebate dollars that were passed on?  
 2 A. I knew that they were passing it on.  
 3 I didn't know, you know, whether it was 50 percent  
 4 or 60 percent or 70 or, as they allege here,  
 5 higher.  
 6 Q. All right. Why would you not have  
 7 been interested in what percentage of revenues  
 8 that Express Scripts received from Wyeth were  
 9 rebate dollars that were passed on versus other  
 10 fees that were not?  
 11 A. Because it's not the primary area of  
 12 my report. My report's primary interest was how  
 13 these rebate structures changed the market, not  
 14 the amount of money that was saved by the PBM or  
 15 passed on to the third-party payer. That would  
 16 primarily be the area of interest for those  
 17 testifying for economic issues within the plan.  
 18 Q. Because you'd agree that certainly  
 19 if you were looking at this from an economic  
 20 matter, you would have to understand those issues?  
 21 A. I'm not an economist. I don't know  
 22 what an economist would need.  
 23 I know, though, that my primary  
 24 interest was did they have rebates, how were they

1 annual basis.  
 2 So I think the premise you're  
 3 making -- I don't want to put words in your  
 4 mouth -- is that these rebate dollars going back  
 5 somehow go back into the benefit of the payer, and  
 6 I don't -- I don't think that's consistent with  
 7 the market.  
 8 Q. Okay. And all I'm asking is is  
 9 you're saying that you don't think that that's  
 10 consistent with the market, but you haven't made a  
 11 study of whether it did or didn't happen in this  
 12 case, have you?  
 13 A. No, I haven't.  
 14 Q. Let me ask you about PBMs more  
 15 generally and the business. On Page 41 of your  
 16 report --  
 17 A. Are we done with this?  
 18 Q. For that page, yes, sir.  
 19 A. Okay. You said 41?  
 20 Q. Yes.  
 21 A. Okay.  
 22 Q. It's a headline, "Rebates now  
 23 represent" -- you see that? In the third  
 24 paragraph, you state that "As the PBM" -- "PBM

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1 industry competes aggressively for new clients" --  
2 let me just stop right there and ask you about  
3 that first -- that first part.  
4 Is it your understanding that --  
5 that PBMs do aggressively compete for new clients?  
6 A. I do, yes.  
7 Q. And so health plans would go to  
8 various PBMs, whether it's -- it's your company,  
9 PCN, or Express Scripts or Medco or these others,  
10 and try to get the best deal that they can for a  
11 pharmacy benefit; correct?  
12 A. Yes.  
13 Q. And if the -- if the PBMs did not  
14 receive rebates or other administrative fees, do  
15 you think -- in your experience, would that impact  
16 what the PBM charge the client health plans and  
17 MCOs for their services?  
18 A. You bet. They can't operate on no  
19 revenue.  
20 Q. All right. And that the health  
21 plan's cost in essence would then increase?  
22 A. That's a complex assumption. If --  
23 if the --  
24 Q. Well, you said they can't operate

1 of the pharmacy benefit.  
2 Q. Okay. And is that how PCN does  
3 business?  
4 A. That's not how PCN does business.  
5 Q. All right. And at PCN, is it true  
6 that the receipt of rebates and administrative  
7 fees actually lower health plan costs to the --  
8 A. No, it's not. That's the point I'm  
9 trying to make here, but you keep limiting my  
10 ability to respond.  
11 PCN, because it does an 80-20 split  
12 or better --  
13 Q. Right.  
14 A. -- charges for its administrative  
15 services. When we go into -- and I've been to  
16 these marketing meetings when the Merck-Medcos and  
17 the Express Scriptses come in -- they offer to  
18 give those services away free.  
19 Q. And so they actually charge lower  
20 rates to health plans than PCN?  
21 A. They do even better than that.  
22 They'll come in and they'll offer a cash bonus to  
23 get the business up front, which is some  
24 percentage of the rebate up front.

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1 with no --  
2 A. I said the PBM cannot operate with  
3 no revenue.  
4 Q. Right.  
5 A. Let me describe to you what the  
6 typical competition is like.  
7 Q. Let's -- we can do that in a little  
8 bit, but can you just answer my question in terms  
9 of whether the health plan's cost would increase  
10 in your experience if the PBM did not pass on --  
11 if the PBMs didn't receive rebates or  
12 administrative fees?  
13 A. The cost for the -- the cost for the  
14 administration of the health -- of the pharmacy  
15 benefit would probably increase. The overall cost  
16 of the pharmacy benefit might drop, which is  
17 what's really important.  
18 Q. Why do you think that?  
19 A. Again, it goes back to the function  
20 of if you set up the product so that there is a  
21 hundred-dollar branded product and a \$20 generic  
22 product and you incentivize the movement of the  
23 market to the hundred-dollar product and then give  
24 a \$10 rebate, you've increased the cost of the --

1 Q. And -- and these health plans that  
2 are out there, the teamsters union, and so on,  
3 that -- that we talked about, are they now  
4 frequently advised by groups like Mercer that we  
5 talked about, groups like that?  
6 A. The world is a very complex place.  
7 Q. Just generally.  
8 A. I'm going to tell you that the  
9 Mercers do advise. I'll leave at that, and if you  
10 want more, I'll give it to you.  
11 Q. Do you think that -- is it your  
12 experience that health plans are more often than  
13 not -- do they have a consultant that they're  
14 working with to advise them in connection with  
15 establishing a PBM benefit?  
16 A. Most of the self-funded do. The  
17 large players like HealthNet, probably not.  
18 Q. All right. And is it your  
19 experience that these consultants that would be  
20 helping health plans would have more than one  
21 client?  
22 A. Sure.  
23 Q. So they would have reason to -- to  
24 not only have visited with a company like yours,

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1 like PCN, but in the past have talked to Express  
 2 Scripts, talked to Medco, talked to the other PBMs  
 3 that are out there offering a pharmacy benefit;  
 4 right?  
 5 A. Yes.  
 6 Q. All right. So from that experience,  
 7 they would be in a position to advise their  
 8 clients in terms of which plan is offering the  
 9 best deal as it relates to administrative costs,  
 10 rebates, and other charges, right, at least in  
 11 their -- in their view?  
 12 A. In their view. However, many of  
 13 those organizations also have the PBMs, the large  
 14 PBMs as clients.  
 15 Q. And -- and so that's another  
 16 conflict in your view?  
 17 A. You bet.  
 18 Q. Okay. And which are the -- which  
 19 are the conflicted advisers that -- that you're  
 20 referring to?  
 21 A. Almost all the big houses.  
 22 Q. Is Mercer a conflicted --  
 23 A. As an example.  
 24 Q. Are they -- who are they conflicted

1 A. AdvancePCS, yes.  
 2 Q. And does PCN pay Mercer money?  
 3 A. No.  
 4 Q. So these other PBMs, they're out  
 5 there in your view creating conflicts --  
 6 A. I don't --  
 7 Q. -- so that the -- so that --  
 8 A. I don't know that they're a  
 9 conflict. There is a conflict whether it started  
 10 by Mercer or them. I think most reasonable people  
 11 would think there's a conflict.  
 12 Q. So in your view, the health plans  
 13 then are not being appropriately advised by Mercer  
 14 because of the conflicts with the PBMs?  
 15 A. I think the advice they get is  
 16 highly likely to be influenced by the  
 17 extracurricular relationships that they have.  
 18 Q. These conflicts that you're talking  
 19 about, is it your view that these are rampant in  
 20 the industry?  
 21 A. Yes.  
 22 Q. And -- and the advisers that are all  
 23 out there are on the payrolls of the PBMs?  
 24 A. I didn't say that.

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1 by in your view?  
 2 A. Well, their -- they have as a client  
 3 all of the big top-tier PBMs and they are  
 4 functioning as a consultant to their clients, who  
 5 are the employers.  
 6 Q. So their clients include, let's  
 7 say -- do they include PCN?  
 8 A. No, no. Their clients would be, you  
 9 know, the -- a school district or a paper company  
 10 or something like that.  
 11 Q. So the -- and now the PBMs, do they  
 12 have -- you're saying that they have a financial  
 13 arrangement as well with a group like Mercer?  
 14 A. They have -- they have a client  
 15 relationship wherein Mercer helps them design  
 16 their -- their offering to the market and there's  
 17 a relationship.  
 18 Q. So -- so does Medco, for example --  
 19 do they use Mercer? Do they pay Mercer money?  
 20 A. Sure. They're a client of Mercer's.  
 21 Q. And Express Scripts?  
 22 A. Yes.  
 23 Q. They pay Mercer money. AdvancePCS  
 24 would be paying money?

1 Q. Well, is it -- is it your view that  
 2 a vast majority of them are?  
 3 A. I think that they have client -- the  
 4 larger consulting houses, particularly Mercer, has  
 5 client relationships with the top-tier PBMs.  
 6 Q. Do you think that most of the --  
 7 most of the plans that are receiving consulting  
 8 advice in terms of their contracts are getting  
 9 advice that is tainted by conflicts?  
 10 A. I just -- I do not know the answer  
 11 to that. I think that it's an environment that's  
 12 highly likely to be influenceable.  
 13 Q. All right. Have you ever quantified  
 14 this in any way?  
 15 A. No, I have not. I didn't do a  
 16 study.  
 17 Q. You haven't done any study?  
 18 A. Right.  
 19 Q. It's just a general view that you  
 20 have out there --  
 21 A. No.  
 22 Q. -- that --  
 23 A. It's commonly known in the industry  
 24 that this is going on.

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1 Q. All right. And when you -- when you  
2 say that it's commonly known in the industry, are  
3 there -- are there any published studies that talk  
4 about this rampant conflict between the folks that  
5 are advising the health plans and the PBMs?

6 A. Not that I know of.

7 Q. All right.

8 A. It could be, but it just --

9 Q. You have never seen any?

10 A. I haven't -- I haven't referenced  
11 it. I didn't discuss it. I didn't footnote it.

12 Q. Okay. And the -- have you seen  
13 any -- in your report, you talk about lawsuits  
14 that have been filed against PBMs, and so are  
15 there lawsuits against these consulting groups  
16 because of their -- this -- this conflict between  
17 them and the PBMs?

18 A. No. The primary -- the primary  
19 legal cases that I've been referring to this  
20 afternoon involve the steering of the market to  
21 more expensive branded products and the games that  
22 are being played with generics.

23 Q. But it's -- it's your view, going  
24 back to my question, sir, that -- that health

1 That's one of the large consulting houses. And I  
2 don't know if they participate in that. I think  
3 the one that's most involved is Express -- is  
4 Mercer.

5 Q. So somebody at Anon --

6 A. Actually -- I'm sorry. I actually  
7 got feedback from one of the Mercer partners that  
8 they have these PBMs as clients. And it was the  
9 partner in their Portland office, and I don't  
10 recall --

11 Q. What's his --

12 A. -- his name.

13 Q. What's his name? But he's in the  
14 Portland office.

15 The Anon, A-n-o-n, that you  
16 mentioned --

17 A. A-n-o-n.

18 Q. -- does -- does that group provide  
19 consulting to health plans?

20 A. I don't believe they do.

21 Q. What -- what business are they in?

22 A. No. I'm sorry. They do provide  
23 consulting, not to the PBMs.

24 Q. How do you know that?

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1 plans are not being well advised because of  
2 conflicts from their consultants?

3 A. I'm quite suspicious of that. I  
4 think everybody is, or most people are.

5 Q. Is there any congressional  
6 investigations which are aware of this or anything  
7 like that?

8 A. No.

9 Q. When you say it's common -- commonly  
10 known in the industry, who have you heard this  
11 from? Mr. Bystrom?

12 A. Among others.

13 Q. Anybody else you can think of?

14 A. I heard it from the entire marketing  
15 staff at PCN.

16 Q. Anybody else?

17 A. Let's see if I've heard it within  
18 the consulting industry. I think that I heard it  
19 from some of the consultants in the market, but  
20 I'm not -- I'm not going to be able to give you  
21 the name. I think it came from Anon, A-n-o-n, but  
22 I don't --

23 Q. A-o --

24 A. I don't have a name. A-n-o-n.

1 A. We had a discussion about this  
2 during the competitive meet marketing structure  
3 for the city of Portland about a year to a year  
4 and a half ago.

5 Q. Okay. So in the instance of  
6 somebody like Anon that doesn't have the conflicts  
7 that you described, are they advising the city of  
8 Portland in connection --

9 A. They are -- they are advising the  
10 city of Portland.

11 Q. All right. And just let me finish  
12 my question, if you would.

13 So in a case like Anon where they're  
14 advising the city of Portland, they're presumably  
15 in the position to examine the differences between  
16 what Express Scripts is -- is offering in terms of  
17 rebate dollars, what a Medco is offering in terms  
18 of rebate dollars, what PCN is offering in terms  
19 of rebate dollars, what each of them is charging  
20 for administrative fees and to advise their  
21 clients in terms of what's the best deal; right?

22 A. They would -- that's correct.

23 Now, I'm going to qualify it again.

24 You can add up all the -- you can add up all the

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1 columns and when you have one company that is  
 2 offering administrative fees for the pharmacy  
 3 benefit that's straight up, Here's what we do and  
 4 charge you for it, versus someone who says, I will  
 5 come in and do it all for free and I'll give you a  
 6 check up front for a portion of the rebate, it's a  
 7 very hard thing for the -- for the customer or for  
 8 the client not to go with those options.

9 The reason I'm so skeptical of the  
 10 numbers that you're throwing around here for  
 11 Merck-Medco is these companies cannot survive --  
 12 and, in fact, they're some of the most profitable  
 13 in America -- on no revenue. You know, they're  
 14 giving their core services away and you're telling  
 15 me that they're passing through almost all of  
 16 their rebates, and I just -- something doesn't  
 17 compute here.

18 Q. What makes you think that Medco is  
 19 one of the most profitable companies in America,  
 20 sir? Have you ever looked at their financial  
 21 statements?

22 A. I have. I can't --

23 Q. Okay. What's their net income?

24 A. I've actually quoted their net

1 A. That's my -- my chart.

2 Q. All right. And do you think they  
 3 have 35 billion in revenues?

4 A. I will just tell you that HSG and  
 5 Managed Care Diagnostics' report indicated that.

6 Q. Do you -- to go back to my question,  
 7 did you -- do you know how many -- do you know  
 8 what their net income is? Let's assume they had  
 9 35 billion.

10 A. Net versus gross.

11 Q. Let's assume that they had 35  
 12 billion in revenue. Okay. All that money to pay  
 13 all their employees, pay for all -- everything  
 14 that they do. Do you know -- do you know what the  
 15 net income would be of the company?

16 A. This number is their gross income  
 17 that would include paying for product. The net  
 18 would be after product was paid for, is the way I  
 19 read this.

20 Q. This is their revenues; right?

21 A. This is their gross revenues.

22 Q. Right. So do you know what their  
 23 net is?

24 A. I'd have to look it up.

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1 income here, and again, I don't recall which year  
 2 it was. But give me a second and I'll find it.

3 Q. What you quoted, sir, was the number  
 4 of scripts from Medco, not their net income;  
 5 right?

6 A. Well, just hold on a second. I'll  
 7 give you the numbers.

8 Starting at Page 24, you have the  
 9 total number of lives covered and on Page 26 for  
 10 the Big Four, you have the PBM revenue given in  
 11 millions. So 35 million -- no. That's -- I think  
 12 that's 30 -- 35 million -- no, it isn't. It's --  
 13 it's -- it is -- it's -- this is listed here as  
 14 35,000. This is -- the source for this is from  
 15 Wyeth documents and it is for the year 2003,  
 16 September 2003. And it's showing Medco's PBM  
 17 revenue in millions and the units on the Y axis --  
 18 this is 35,000. So 35 -- if -- according to this  
 19 chart, it's 35 thousand million. That's a lot.

20 Q. Was this 35 billion?

21 A. That's -- that's the way you'd read  
 22 that.

23 Q. Is -- that's the way your chart has  
 24 it, at least?

1 Q. You haven't looked?

2 A. I did, but I don't happen to have it  
 3 on the top of my head here.

4 Q. Do you know if it's -- if they have  
 5 a 1 percent net income or less?

6 A. I think it's more.

7 Q. Do you know if it's -- how much  
 8 more?

9 A. I would -- again, I'm going out on a  
 10 limb here. I have looked at their financial  
 11 statements. My bet is that they're something less  
 12 than 5 percent.

13 Q. Okay. When you say -- you make  
 14 these --

15 A. Probably somewhere around 3.

16 Q. -- these grand statements, okay,  
 17 which you have a habit of doing, Dr. Gibson -- you  
 18 said they're one of the most profitable companies  
 19 in America. All right. And then I ask you what's  
 20 their net income.

21 What's the basis for you saying  
 22 they're the most profitable company in America if  
 23 you don't know what their net income is?

24 A. I didn't say they -- they were a --

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1 they were one of the more profitable companies in  
2 America is what I said.  
3 Q. Okay. And -- and how can you say  
4 they were one of the more profitable companies in  
5 America if you don't know what their net income  
6 income is?

7 MR. COHEN: Object to the form.

8 A. I do -- I do know what it is. I've  
9 seen it. I just don't happen to have it with me  
10 right now.

11 BY MR. DOBIE:

12 Q. Okay. And do you -- and sitting  
13 here today under oath, it's your belief that  
14 they're one of the more profitable companies in  
15 America, Merck-Medco is?

16 A. They are a -- they are -- they are  
17 viewed as a very profitable company.

18 Q. And are you talking about measured  
19 on the basis of -- of revenues to income in terms  
20 of their margins? Are you talking about the total  
21 dollar amount of their net income? What's --

22 what's the basis for your most profitable --

23 A. Return to shareholders and the  
24 profitability for shareholders. These are

1 MR. COHEN: Object to the form.

2 Mischaracterizes the testimony.

3 A. That's -- that's not even close to  
4 what I said. What I -- I'll restate where I am.

5 I'm saying that you are presenting  
6 data to us today that we've never seen before that  
7 says that -- that Medco is returning percentage of  
8 rebates in excess of what PCN does and at the same  
9 time Medco is in the market providing their core  
10 services at little or no fees to the customers.  
11 And I'm telling you I find that not credible. I  
12 think that the data you're getting does not  
13 include all of their rebate funding.

14 BY MR. DOBIE:

15 Q. How many current lives does PCN  
16 have, sir?

17 A. 1,200 -- 1.2 million.

18 Q. And how many does -- does Medco  
19 have?

20 A. Medco as of June 2001 was stated to  
21 have 65 million.

22 Q. Do you -- do you think that they run  
23 a more efficient operation than PCN, sir, and as a  
24 result of that they're able to offer health plans

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1 publicly traded companies.

2 Q. Are you talking -- so are you  
3 including the amount that their stock has gone up?

4 A. The valuation of their stock.

5 Q. Okay. All right. So -- so are  
6 they -- okay. So you're -- their market  
7 capitalization has gone up?

8 A. Which reflects their profitability.

9 Q. And --

10 A. And you -- then you can get the  
11 exact number on profitability out of their annual  
12 statements.

13 Q. Now, we're going kind of around and  
14 around here, but what you're -- what you're saying  
15 is that it's impossible -- your conclusion is,  
16 even though you haven't read the testimony of the  
17 witnesses under oath, you hadn't ever looked at  
18 the document before, but it's your conclusion, Dr.  
19 Gibson, that it's impossible that they're paying  
20 on 90 percent of their rebate on Premarin to  
21 health plans because of the fact that their stock  
22 price has increased, and that means that they're  
23 one of the more profitable companies in America?

24 A. That's --

1 a better deal than PCN?

2 A. I have no opinion as to whether  
3 they're more efficient. I will tell you that  
4 administrative fees are generally standard across  
5 the industry. In other words, you don't -- what  
6 the customer sees are administrative fees that are  
7 consistent.

8 I am telling you I do not find it  
9 particularly credible that you are being told  
10 that -- that Medco has no real substantial  
11 revenue, that they give their core services away.  
12 The only -- the only way that I could possibly  
13 accept that that is realistic is that their 10  
14 percent that they're saving or 20 percent that  
15 they're saving, whatever the number is, to  
16 themselves is so huge that it represents a  
17 substantial amount of money that's not going  
18 through to the client.

19 Q. Or could it also be that they're  
20 making money on other products, PPIs? And, for  
21 example, do you know how rebate dollars on -- in  
22 this therapeutic class, estrogens, compare to the  
23 rebate dollars that a PBM makes in other  
24 therapeutic categories?

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1 A. Rebates are set by class for a whole  
2 host of reasons. I'm totally ignoring now  
3 placement and tier positioning and all of that.  
4 Within class, the rebate dollars tend to fluctuate  
5 on the options available.

6 So that if -- if -- take the  
7 category of serotonin reuptake inhibitors. If  
8 there are four options available, the product  
9 obtaining favorable positioning on the formulary  
10 will generally pay a higher rebate to obtain that  
11 than a drug in a class that's exclusive.

12 Q. Do you know, sir, how many  
13 therapeutic classes PCN has on formulary?

14 A. Classes?

15 Q. Yes. How many -- how many  
16 therapeutic --

17 A. Probably around 15. I don't -- I  
18 don't -- I don't know.

19 Q. Okay. Do you know what the rebate  
20 dollars are in terms of what -- what class most of  
21 the rebate dollars fall into? For example, is it  
22 in PPIs, is it in estrogens, is it in -- in beta  
23 blockers? I mean, do you know -- do you know  
24 where most of the rebate dollars fall --

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1 A. You can --

2 Q. -- at PCN?

3 A. I'll say I do not know the exact  
4 numbers. I can infer where they are, and most  
5 knowledgeable people can on just about any PBM's  
6 product line. It's a function of the volume of  
7 drugs that are used. If you have a low number,  
8 the unit cost is low. That's what makes Premarin  
9 such an important player, because it's such a  
10 commonly prescribed drug, so it doesn't need to be  
11 a top-tier cost drug per unit. It generates a lot  
12 of rebate dollars because it's a big part of the  
13 number of units moved.

14 If you look at any plan, the actual  
15 dollars spent or the units dispensed, the highest  
16 tier usually are mental health drugs. Also high  
17 frequently are analgesics, and that class can go  
18 from nonsteroidals all the way to narcotic  
19 analgesics. Somewhere in the middle of the range  
20 are usually drugs relating to women's health.

21 Q. So it's your belief that the dollars  
22 spent by a particular health plan on a pharmacy  
23 benefit, women's health, that category would fall  
24 sort of in the middle of the range, the cost of

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1 the product?

2 A. Yes, somewhere in the middle tier of  
3 total spending would be women's, particularly  
4 hormone replacement therapy.

5 Q. Okay. And do you know -- you've  
6 given us your best estimate in terms of where --  
7 where the dollars are spent as it relates to  
8 different categories of products here and you've  
9 got women's health in the middle.

10 Do you know whether rebate dollars  
11 match that? In other -- in other words, is -- is  
12 it a -- do you have -- you said 15 -- 15 classes.

13 Let me finish the question so Mac  
14 can get it down.

15 If you have 15 classes of products  
16 at PCN, as you -- as you testified to, would --  
17 would Premarin be 10 percent of the rebate  
18 dollars, would it be 90 percent of the rebate  
19 dollars? Do you have any sense of that?

20 A. Overall, Premarin's -- I'm thinking  
21 out loud here to get you an answer.

22 Overall, the rebate structure for  
23 Premarin is at about 10 percent, according to what  
24 I read in your documents, which, incidentally, in

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1 the range of rebates is in the midrange. If -- if  
2 there were other conjugated estrogens they were  
3 actually competing against heads up, it would --  
4 you would expect it to be higher than 10 percent,  
5 somewhere between 10 and 15 percent.

6 But if I could back into the number  
7 for what would likely be the rebate number for --  
8 for Premarin and hormonal replacement through  
9 Premarin family of drugs, my calculating about 10  
10 percent of what the total revenue -- total cost  
11 was to the plan. Now, how that relates to other  
12 classes, I've never looked at that.

13 Q. I mean, I guess what I'm wondering,  
14 sir, is just to be clear, you never looked at what  
15 percentage of Medco's rebate dollars come from the  
16 Premarin family of products versus, let's say,  
17 other categories?

18 A. I don't think that would commonly be  
19 available.

20 Q. Right.

21 A. Those are all, again, proprietary  
22 numbers. You get total numbers frequently, but  
23 not -- not by class or by drug.

24 Q. Have you looked at any documents in

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1 this litigation that give you the amount of rebate  
2 dollars paid to any PBMs and compare the amount  
3 for Premarin versus any other product that Wyeth  
4 sells?

5 A. I didn't see or study contracts  
6 other than for Premarin-related products.

7 Q. Okay. But did you look -- I wasn't  
8 asking about contracts. I asked whether you  
9 looked at documents that talk about what  
10 percentage of rebate dollars PBMs received from  
11 Wyeth for Premarin as opposed to for other  
12 products.

13 A. No.

14 Q. Okay. So when you testified that  
15 you can't believe -- let me -- let me back up.

16 Do you think these people from Medco  
17 are lying?

18 A. I'm just saying that I'm having  
19 trouble with the data you're presenting to me  
20 today for the first time. I'm skeptical of that  
21 data.

22 Q. All right. How about like Blue  
23 Cross of California? A hundred percent of the  
24 rebates dollars passed on is there -- is the

1 Q. In Blue Shield of California.

2 A. Yes.

3 Q. That doesn't -- that doesn't  
4 surprise you?

5 A. Not for that arrangement --

6 Q. All right.

7 A. -- with Argus.

8 Q. And -- and don't you think, as you  
9 mentioned before, given that this is a  
10 competitive -- and you say on Page 41 of your  
11 report, and you agreed with this, that the PBM  
12 industry is aggressively competing for new  
13 clients.

14 Given that that's the case, that  
15 you've got people like PCN out there passing on 80  
16 percent of the rebates, Blue Shield of California  
17 passing on a hundred percent of the rebates,  
18 wouldn't the other PBMs have to pass on a high  
19 percentage of the rebates in order to compete with  
20 you-all --

21 MR. COHEN: Object to the form.

22 A. No.

23 BY MR. DOBIE:

24 Q. -- if they're advised by --

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1 testimony that the contract manager there. Do you  
2 think -- do you think that's -- that's also hard  
3 to believe?

4 A. Is that a -- is that a captive PBM  
5 for Blue Cross of California? I can't recall.

6 Q. I'm sorry. Blue Shield of  
7 California.

8 A. Well, okay. Yes. That's a very  
9 interesting example. They've got a very different  
10 relationship. They have a company known as Argus  
11 that administers their pharmacy benefit. That  
12 means they do the claims processing. The inhouse  
13 people within Blue Shield negotiate all the  
14 rebates, manage the network, and so I wouldn't be  
15 at all surprised that they would have a hundred  
16 percent. I'd be surprised if it was otherwise,  
17 because they have fractionated the PBM product  
18 into its individual components and all the rebate  
19 revenue stays within Blue Shield.

20 Q. Okay. So -- so it doesn't surprise  
21 you that a hundred percent of the rebate dollars  
22 would be passed on by -- by Blue Shield?

23 A. In that model, you didn't -- the  
24 word "Medco" didn't ever come up in that sentence.

1 A. Because --

2 Q. Let me finish the question.

3 -- if they're being advised by  
4 consultants, as you -- as you indicated?

5 A. Even under consultation with a  
6 nonconflicted consultant, it's very hard for a  
7 customer to take a free gift of administration.  
8 Even though they know in the back of their mind  
9 that it's going to get paid for on the rebate  
10 arrangement, they -- they don't budget the rebate  
11 dollars in their yearly financial plan, and truly  
12 there's an add-on at the end. So in the marketing  
13 environment, they get -- they can go -- these --  
14 these -- these pharmacy managers or benefit  
15 managers in most of the companies, like, say, the  
16 city of Portland, are middle managers. They're  
17 not senior management.

18 Q. All right. But that's -- at the end  
19 of the day, it's a decision that those plans are  
20 making then whether to go with a PCN and get 80  
21 percent of the rebates passed on, a Blue Shield of  
22 California, a hundred percent of the rebates  
23 passed on, or -- or a Medco and get some of the  
24 money up front; correct?

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1 A. First of all, Blue Shield is not  
2 selling their -- that PBM product as a -- as a --  
3 Q. Let me change my hypothetical.  
4 At the end of the day, it's the --  
5 it's then the decision on the part of these plans  
6 whether they want to take some of the money up  
7 front and get smaller rebates as opposed to going  
8 with somebody like a PCN and having 80 percent or  
9 more of the rebates passed on; right?  
10 MR. COHEN: Object -- object to the  
11 form.  
12 A. We -- I'm starting to get lost here,  
13 but I'm saying that the end of the day, it's the  
14 customer that makes the decision.  
15 BY MR. DOBIE:  
16 Q. Yes.  
17 A. We got into this conversation  
18 wherein I was skeptical that you were giving me an  
19 environment that's too good to be true, that you  
20 have a Medco coming in with no administrative fees  
21 and greater than the stated PCN rebate returns,  
22 and I'm just saying that that doesn't smell right.  
23 Q. You're the one who's saying that  
24 there's no administrative fees. My hypothetical

1 small they were, quite frankly, in relation to the  
2 rebate dollars, but you don't know about that  
3 either. I don't need to educate you, because you  
4 haven't done -- you haven't looked at that. It  
5 wasn't necessary for you to render your opinions.  
6 A. Okay.  
7 Q. Right?  
8 A. No, it's not right. What I'm --  
9 what I'm asking you --  
10 Q. Was it -- was it --  
11 A. -- is did -- did he testify that he  
12 was having administrative fees that he was passing  
13 through in tandem with these rebate dollars that  
14 you've presented to us.  
15 Q. I can't answer your questions.  
16 A. Oh.  
17 Q. Okay.  
18 MR. COHEN: Gordon, is this --  
19 A. But see, you're the one giving me  
20 the --  
21 BY MR. DOBIE:  
22 Q. I'm giving you a hypothetical. I  
23 want to get your opinion based upon a hypothetical  
24 or a statement of facts from a witness.

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1 is simply what the man testified to in his  
2 deposition. He didn't say they didn't have  
3 administrative fees. You've thrown that into my  
4 hypothetical.  
5 A. Well, I'm telling you that that's --  
6 Q. That --  
7 A. It's my experience that that's  
8 exactly what's going on with that.  
9 Q. Okay. But what -- what I've said  
10 is -- is exactly what the witness has testified to  
11 under oath, which you haven't reviewed.  
12 A. Right.  
13 Q. All right.  
14 A. And you're saying that in that  
15 deposition he said that they're charging  
16 administrative fees and they are giving greater  
17 rebates than what we have quoted here. That's  
18 what he testified to?  
19 Q. He testified that 90 percent of the  
20 rebates on the Premarin product were passed on.  
21 A. And what did he say about the  
22 administrative fees?  
23 Q. The administrative fees were -- were  
24 discussed in relation to how big they were or

1 A. And my -- my opinion is based on the  
2 hypothetical you present is that it's not  
3 realistic.  
4 MR. COHEN: Is this a good time to  
5 break?  
6 MR. DOBIE: Sure.  
7 THE VIDEOGRAPHER: This concludes  
8 today's proceeding in the deposition of  
9 David Gibson. The time is 6:03. We're now  
10 off the record.  
11 \* \* \*  
12 (Whereupon, the deposition adjourned  
13 at 6:03 p.m.)  
14 \* \* \*  
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## INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the corrections you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

## ACKNOWLEDGMENT OF DEPONENT

I, \_\_\_\_\_, do hereby certify that I have read the foregoing pages, \_\_\_\_\_, and that the same is a correct transcription of the answers given by me to the questions herein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

DATE

Subscribed and sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_, 200\_.

My commission expires: \_\_\_\_\_

Notary Public

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## C E R T I F I C A T E

I hereby certify that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

It was requested before completion of the deposition that the witness, DAVID J. GIBSON, M.D., have the opportunity to read and sign the deposition transcript.

McKINLEY WISE, CM

Dated: May 28, 2004

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